Authorization to Use or Disclose Protected Health Information

Drew Alikakos, M.S.

Patient Name:_____

Address: _____

Date of Birth: _____ Date of Request:_____

As required by the Privacy Regulations, Drew Alikakos, M.S. may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office:

_____

Patient Health Information authorized to be disclosed:

_____

_____

For the specific purpose of (describe in detail)

_____

_____

Effective dates for this authorization: _____/_____/_____ through _____/_____/_____
This authorization will expire at the end of the above period.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.
I understand I have the right to:
Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.

1. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
2. Inspect a copy of Patient Health Information being used or disclosed under federal law.
3. Refuse to sign this authorization.
4. Receive a copy of this authorization.
5. Restrict what is disclosed with this authorization.
   I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

_____ _____

Signature or Patient or Patient's Authorized Representative *Date*

_____ _____

Authorized Signature of Facility *Date*

Drew Alikakos, M.S.
Licensed Psychologist
811 West Chester Pike
West Chester, PA 19382

Addiction & Psychological Therapy

Drew Alikakos
Licensed Psychologist

811 West Chester Pike
West Chester, PA 19380
(610) 696-0325

Authorization to Release Information

I, _____ authorize Drew Alikakos, M.S. to release an evaluation summary and treatment plan updates to my Primary Care Physician to encourage the best possible communication among the professionals who are involved in my care.

Name of Primary Care Physician _____

Address of Primary Care Physician _____

_____

I understand that this consent is valid for a period from _____ to _____

I understand that I may revoke this authorization at any time by sending a written notice to Drew Alikakos, M.S. at the above address.

_____ _____
Clients Signature Date

_____ _____
Witness Signature Date

Patient Name:_____

Patient ID:_____

ATTACHMENT E
MAGELLAN BEHAVIORAL HEALTH
MEMBERS' RIGHTS AND RESPONSIBILITIES STATEMENT

Statement of Members' Rights

- Members have the right to be treated with dignity and respect
- Members have the right to fair treatment: regardless of their race, religion, gender, ethnicity, age, disability or source of payment.
- Members have the right to have their treatment and other member information kept private. Only where permitted by law, may records be released without member permission.
- Members have the right to easily access timely care in a timely fashion.
- Members have the right to know about their treatment choices. This is regardless of cost or coverage by the member's benefit plan.
- Members have the right to share in developing their plan of care.
- Members have the right to information in a language they can understand.
- Members have the right to have a clear explanation of their condition and treatment options.
- Members have the right to information about Magellan, its practitioners, services and role in the treatment process.
- Members have the right to information about clinical guidelines used in providing and managing their care.
- Members have the right to ask their provider about their work history and training.
- Members have the right to give input on the Members' Rights and Responsibilities policy.
- Members have the right to know about advocacy and community groups and prevention services.
- Members have a right to freely file a complaint or appeal and to learn how to do so.
- Members have the right to know of their rights and responsibilities in the treatment process.
- Members have the right to receive services that will not jeopardize their employment.
- Members have the right to list certain preferences in a provider.

Approved August 2, 2002

Statement of Members' Responsibilities

- Members have the responsibility to treat those giving them care with dignity and respect.
- Members have the responsibility to give providers information they need. This is so providers can deliver the best possible care.
- Members have the responsibility to ask questions about their care. This is to help them understand their care.
- Members have the responsibility to follow the treatment plan. The plan of care is to be agreed upon by the member and provider.
- Members have the responsibility to follow the agreed upon medication plan.
- Members have the responsibility to tell their provider and primary care physician about medication changes, including medications given to them by others.
- Members have the responsibility to keep their appointments. Members should call their providers as soon as they know they need to cancel visits.
- Members have the responsibility to let their provider know when the treatment plan isn't working for them.
- Members have the responsibility to let their provider know about any problems with paying fees.
- Members have the responsibility to report abuse and fraud.
- Members have the responsibility to openly report concerns about the quality of care they receive.

My signature below shows that I have been informed of my rights and responsibilities, and that I understand this information.

X _____

Member signature Date

The signature below shows that I have explained this statement to the patient. I have offered the member a copy of this form.

_____

Provider Signature Date

Addiction & Psychological Therapy
Drew Alikakos, M.S. Licensed Psychologist

PATIENT CONSENT FOR USE AND /OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT,
PAYMENT AND HEALTHCARE OPERATIONS

_____, hereby states that by signing this Consent, I acknowledge and agree as follows:

1) The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and /or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2) The Practice reserves the right to change its privacy Practices that are described in its Privacy Notice, in accordance with applicable law.

3) I understand that , and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me: and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.

4) The Practice may use and / or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

5) I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

6) I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

7) I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

8) I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.
I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Individual (PRINTED)	Signature of Individual
Signature of Legal Representative (Guardian. Parent if a minor)	Relationship
Date Signed	Witness

Addiction & Psychological Therapy
Drew Alikakos, Licensed Psychologist

PRIVACY CONFIDENTIALITY STATEMENT
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

DISCLOSURE OF INFORMATION

We may disclose information to other healthcare professionals and/or your insurance carrier for treatment. payment or healthcare operations. Additional disclosures may be necessary to comply with Workers' Compensation and Public Health Laws as well as Judicial proceedings. We may contact a family member or other authorized person in the event of an emergency. Be assured that we will not disclose any information without your expressed written consent unless compelled to do so by legal authority. Further you will be contacted by phone or mail in the event a request for information is made.

FACILITY SET UP

While our examination and treatment room is private, this office utilities an open reception area that is shared with other healthcare professionals. The doctor and staff will maintain policies to ensure privacy, but there may be some inadvertent disclosure to others in the facility at the same time. If there is private information that you need discussed please request to have such discussions in a private room.

YOUR RIGHTS

1) Send us a written request to see or procure a copy of the information that we have about you, or amend your personal information that you believe is incomplete or inaccurate. If we did not create the information, we will refer you to the source, such as another doctors or hospitals.

2) Request additional restrictions on used and disclosures of your health information. We are not required to agree to these requests and in some instances they may be prohibited by law.

3) Request that we communicate with you about medical matters using reasonable alternative means or at an alternative address.

4) Receive an accounting of our disclosures of your medical information, except when those disclosures are made for treatment, payment or health care operations, or the law otherwise restricts the accounting.

5) You have the right to inspect and have a copy of your health information. There is no cost for the first copy; any copy thereafter will be $25.00.

6) You have the right to amend your information. Please note that we have the right to disagree with your amendments. If there is disagreement you will be provided with information about our denial of your amendment and how you may appeal the denial of amendment.

7) You have the right to a copy of the notice upon request.

COMPLAINTS

about your privacy rights or how your privacy is handled at this office can be directed to D.A. Privacy by calling this office or directing a letter to his attention. If you are not satisfied with how this office handles your complaint you may submit a formal complaint to: DHHS (Office of Civil Rights), 200 Independence Ave, S.W., Room 509F HHH Building, Washington, DC 20201

I have read this Privacy Notice and understand my rights contained in this notice. By signing this form I provide authorization and consent to use and disclose my protected health information as noted above.

_____ _____

Name of Patient (PRINTED) Signature of Patient DATE