



General Consent

Completion of this form verifies that:

I HAVE BEEN GIVEN A COPY OF CATHOLIC CHARITIES' "NOTICE OF PRIVACY PRACTICES" AND A COPY OF "CLIENT RIGHTS & RESPONSIBILITIES".

I consent to the use and disclosure of information protected by the Privacy Rule of the Health Insurance Privacy and Accountability Act (HIPAA) of 1996 for the purpose of providing services, obtaining payment for services rendered, and/or to conduct normal agency operations as stated in the *Notice of Privacy Practices* and *Clients Rights & Responsibilities*.

I understand that the services that I will receive while a client of Catholic Charities (CC) are contingent upon my signature on this consent document.

I understand that I have a right to request a restriction as to how CC uses or discloses protected information to carry out service, payment, and operations. I understand that the agency is not required to agree to the restrictions I may request. However if the agency agrees to the request in writing the restriction will be binding until I agree for the restriction to be removed.

Areas for Restriction of Protected Information

- | | | | | |
|-----|----|-----|---------|--|
| 1. | CC | may | may not | contact me by telephone at home
Number(s) authorized _____ |
| 2. | CC | may | may not | contact me by telephone at work
Number(s) authorized _____ |
| 3. | CC | may | may not | contact me by cellular phone
Number(s) authorized _____ |
| 4. | CC | may | may not | contact me by FAX
Number(s) authorized _____ |
| 5. | CC | may | may not | contact me by mail
address(s) authorized _____ |
| 6. | CC | may | may not | contact me by email
address(s) authorized _____ |
| 7. | CC | may | may not | inform others if and when I am present in the building
<i>If CC may share the above information, with whom may it be shared?:</i> _____ |
| 8. | CC | may | may not | contact me about new program opportunities. |
| 9. | CC | may | may not | contact me with news about the agency. |
| 10. | CC | may | may not | contact me for opportunities to become a donor. |

11. Other requests for restrictions _____

Printed Name _____

Signature _____ Date _____

Name of Authorized Personal Representative _____
(if applicable)

Relationship to Client Parent Legal Guardian Other _____

Signature _____ Date _____

Agency Representative Signature _____

(only necessary to affirm restrictions indicated above)