Brightwater
Formerly HDC
HEALTH

INFORMED CONSENT AND AUTHORIZATION

Consent for Treatment I give my consent to the Brightwater Health providers and support staff to provide, coordinate, and/or manage behavioral health services for me.

Authorization for Disclosure of Protected Health Information (PHI) As explained in the Notice of Privacy Practices, I authorize disclosure of my protected health information for the purpose of Brightwater Health's Treatment, Payment, and Healthcare Operations. Brightwater Health may disclose my health information to and access my health information from other providers using a record locator service or patient information service of a health information exchange for treatment unless I object by checking here:

Examples: Brightwater Health providers from whom I accept services, or treatment may share my information with other Brightwater Health providers involved in my care. I understand that for various services Brightwater Health providers are required to or designed to function as a team and will share my information within that team in a confidential manner. I understand the Consultation process between members of a Brightwater Health multidisciplinary team may include confidential discussion about a client. This case Consultation is good practice and helps to ensure high quality care for me.

Assignment of Benefits I authorize all insurance, Medicare or Medicaid benefits, or benefit payments from other sources for claims for my care originating from Brightwater Health to be paid directly to Brightwater Health. I agree to pay the balance due for any services received that are not covered by insurance or grant funding.

Medicare/Medicaid If I am a participant in Medicaid or Medicare programs, I understand the laws, rules, and regulations of these programs shall apply. I may contact the Medicare Coordination of Benefits Contractor at 1-800-999-1118 if I have questions.

Client Information I have received the Client Information booklet informing me of Brightwater Health policies and my rights as a client.

BRIGHTWATER HEALTH Financial policies exist that: A client is required to pay the applicable co-payment amount due at the time of each visit.

I acknowledge I have received the BRIGHTWATER HEALTH **NOTICE OF PRIVACY PRACTICES** that explains how my health information will be handled in various situations. I understand that I can request a copy of the Notice of Privacy Practices from Brightwater Health. I understand an electronic copy of the BRIGHTWATER HEALTH NOTICE OF PRIVACY PRACTICES can be found at https://www.humandevelopmentcenter.org/.

I have been given the opportunity to discuss my concerns and questions about the privacy of my health information, or I may contact the Brightwater Health Privacy Officer at 1401 East First St., Duluth, MN 55805 or toll-free 888-412-9764.

This authorization is valid for one year from the date of signature. I may revoke this consent and authorization at any future time upon written notice to Brightwater Health.

Signature _____ **Date** _____

Printed Name _____

If I am signing as an authorized representative of the client, I am: (Circle one)

Parent of a minor / *Court Appointed guardian/conservator / *Power of Attorney for Healthcare
**Must provide documentation of guardianship, conservatorship, power of attorney for healthcare*

Staff Use Only: ☐ Client/Representative declined to sign. Reason: _____ Initials: _____ Date: _____