

Agreement for Comprehensive Integrated Mental Health Services

I, _____, the client, agree to meet with a licensed provider of the ISU Integrated Mental Health Clinic at the appointment times and places we agree on, starting on _____, 20____.

I have read the following materials:

1. Notice of Privacy
2. Limits of Confidentiality

The ISU Integrated Mental Health Clinic serves dual functions: to provide mental health services for the community and to aid in the professional development of mental health professional students. All services may be offered by graduate students in the Masters of Science in Clinical Psychopharmacology program who are licensed clinical psychologists supervised by licensed medical professionals.

With enough knowledge, and without being forced, I enter into treatment with ISU Integrated Mental Health, I will keep my provider fully up-to-date about any changes in my medications, medical diagnoses, feelings, thoughts, and behaviors. I expect us to work together on any difficulties that occur, and to work them out in my long-term best interests.

Confidentiality: I understand that the ISU Integrated Mental Health clinic abides by the ethical codes established by the Health Insurance Portability & Accountability Act (HIPAA) and the rules and statutes governing the practice of counseling and use of prescription medication in the State of Idaho. These ethical codes and legal statutes require providers to report to responsible persons or state agencies when clients indicate any of the following situations:

- That the client intends to harm self
- That the client intends to harm someone else
- Information as to direct involvement in child abuse or neglect
- Information as to direct involvement in abuse of the elderly or disabled

I also understand confidentiality is limited by the use of supervisory sessions involving practicum students, interns, and supervisors.

Duration of Treatment: Progress will be evaluated at each session every 90 days and parts of this agreement may change as needed. Follow up will be based on discussions with my provider. Our goals may change over the course of treatment in nature, order of importance, or definition. If I am not satisfied by our progress toward goals, I will attempt to make changes in this agreement, and I may stop treatment after giving this provider at least 7 days' notice of my intentions and meeting with the provider for one last time. I understand that I must make and keep follow up appointments at the recommended intervals in order to receive prescription refills. Should I decide to terminate services, I understand I may receive a 30 day supply of refills at my last session.

Medical Records: Medical records are not part of academic records, and no one, other than IMH Clinic Staff, have access to them except under the limits of confidentiality. Complete records are maintained for seven years from the date of our last contact with you. Upon your written request, we will provide appropriate written information regarding your counseling to another licensed mental health care provider or physician of your choice. If you request a release of information to any other individual, we will request personal contact with you in addition to the written release. Your medical record with us is maintained in both paper file and electronic file formats. Both formats are considered confidential, and access to them is restricted to the conditions previously stated.

Fee for Service: This agreement shows my commitment to pay for this provider's services. It also shows this provider's willingness to use and share his or her knowledge and skills in good faith. I agree to pay in cash or check, \$50.00 for an initial session or to re-establish care and \$25.00 for follow-up sessions. I understand that payment is due at the beginning of each session. I understand and accept that I am fully responsible for this fee.

ISU Student Rates: \$20 to establish care and \$10 for follow up

Limitations of Service Provided by ISU Integrated Mental Health Clinic: I understand that ISU Integrated Mental Health Clinic is a training facility and therefore some services may not be provided. Services not provided include, but are not limited to, issues pertaining to parental fitness and custody, court or legally mandated mental competency evaluation, counseling pertaining or associated with criminal proceedings. Further, I understand that other services may not be provided based on the clinical judgment of my provider's supervisor and/or faculty of Idaho State University. I understand that, in the event that such services are required, I will be provided with a list of referrals.

My signature below indicates that I understand and agree with all of the above points.

Signature of Client

Date

I, the provider, have discussed the issues above with the client. My observations of this client's behaviors and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent.

Signature of Provider

Date



Client Intake Information

Please answer all information as completely as possible. Information given is strictly confidential within the limits of the law and beneficial in providing the best possible service. Feel free to ask for assistance. Your counselor will discuss your responsibilities with you in your initial session.

ISU Integrated Mental Health Clinic does not get involved with any legal or disability-related issues or claims.

CLIENT INFORMATION

Client Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____

Preferred Pronoun (eg: she, he, ze, they): _____ Self-identified Gender: _____

Biologic Sex: _____ Sexual Orientation: _____

Primary Language: _____

Parent/Guardian Name (If client is a minor): _____

Client Address: _____

Cell phone: _____

May call: Yes No

May leave message: Yes No

Home phone: _____

May call: Yes No

May leave message: Yes No

Email: _____

May email: Yes No

Current Occupation: _____ Level of Education Completed: _____

Relationship status (ex: Single, married, divorced, separated, significant relationship/s, etc.): _____

Received prior counseling or mental health treatment? Yes No

Yes If yes, please explain: _____

In case of emergency, please contact:

Name: _____ Relationship: _____ Phone: _____

Have you received prior counseling or mental health treatment? Yes No

Yes If yes, please explain:

Was it helpful? Yes No Please explain: _____

What psychiatric medications have you tried in the past?

Medication Name	Strength	Directions	Prescriber	Outcome

PRESENTING PROBLEMS AND CONCERNS

Please describe your reason for seeking treatment at this time and how you will know if it is working:

Have you ever or are you currently contemplating ending your life? No Yes If yes, when? _____

Has anyone in your immediate family attempted or completed suicide? No Yes If yes, when? _____

Please circle any of the following that are currently troubling you: For all of those which you circle, please indicate on a scale from 1 to 10, with 10 being significant, how severe you feel this issue is in your life at the present time.

Abuse	Family	Motivation	Stress
Alcohol/Drug use	Fear	Perfection	Study habits
Anger/Rage	Finances	Procrastination	Suicidal thoughts
Anxiety/Panic	Friends	Relationship	Test anxiety
Appearance/Weight	Grades	Sadness	Time management
Assertiveness	Grief	Self-esteem	Trust
Boredom	Guilt	Sexual harassment	Unhappiness
Career	Helplessness	Sexuality	Worry
Dating	Homesickness	Shyness	Other:
Depression	Hopelessness	Sleep	Other:
Eating problems	Loneliness	Stalking	Other:
Expressing feelings	Meeting people	Staying in school	

Present Family/ Living Situation

Please identify the people currently living with you and the nature of your relationship.

	Name	Age	Relationship	Currently this relationship is: Good, neutral, conflicted, etc.
1				
2				
3				
4				
5				
6				

HISTORY

Health

Are you currently under the care of a medical doctor or other medical health professional: No Yes

Name of Primary Care Physician: _____

Physician Phone : _____

Are you currently taking any prescription medications, vitamins or herbal supplements ? No Yes

If yes, please list each medication below (please include Over-The-Counter Medicines, Dietary Supplements, and Herbal remedies):

Medication Name	Strength	Directions	Prescriber

Do you have any allergies? No Yes If yes, please list: _____

Date of last physical exam: _____ Any significant results: _____

Physical disability: No Yes Chronic illness: No Yes

If yes to either, please explain: _____

Prior psychiatric hospitalizations? No Yes If yes, when: _____

Do you currently exercise: : No Yes If yes, please indicate what type and how many times per week: _____

Are you having any problems with your sleep habits? No Yes If yes, please explain:

Sleeping too little Sleeping too much Poor quality sleep Disturbing dreams Other _____

Are you having any difficulty with appetite or eating habits? No Yes If yes, please explain:

Have you or are you currently using any of the following substances?

Substance	Past or Present use?	Frequency/Amount	Method of use	Level of concern
Caffeine <input type="checkbox"/> No <input type="checkbox"/> Yes				
Alcohol <input type="checkbox"/> No <input type="checkbox"/> Yes				
Tobacco <input type="checkbox"/> No <input type="checkbox"/> Yes				
Recreation or Street Drugs <input type="checkbox"/> No <input type="checkbox"/> Yes (Please list)				
Marijuana/CBD/ Cannabis <input type="checkbox"/> No <input type="checkbox"/> Yes				
E-cigarettes/vape pen <input type="checkbox"/> No <input type="checkbox"/> Yes				

What medical problems have you been diagnosed with (for example, high blood pressure, diabetes, etc):

Diagnosis	Provider who treats	Date diagnosed	How well controlled?

What surgeries have you had (for example, C-section, open heart surgery, back surgery):

Diagnosis	Provider who treats	Date diagnosed	How well controlled?

Have you ever had a head injury, seizure, motor vehicle crash, or motorcycle accidents? If so, please describe:

Type of injury	Date	Treatment given?	Loss of consciousness?

Have you ever been the victim of a crime? No Yes If yes, please list date and briefly describe: Are you currently involved in divorce or child custody proceedings? No Yes If yes, please explain:
Have you ever been convicted of a misdemeanor or felony? No Yes If yes, please explain:

Cultural Beliefs Affecting Treatment

What culture do you identify with?

Strengths and Interests

What are your strengths and interests?

GOALS

What are the goals you hope to achieve in treatment:

- 1.
- 2.
- 3.

Is there anything you would like to add that I have not asked which you would like to include?

Client Signature: _____ Date: _____
Parent/Guardian Signature if under 18: _____ Date: _____
Parent/Guardian Signature if under 18: _____ Date: _____



Informed Consent

(Please read every section and initial each line)

_____ **What to Expect:** Appointments are 30 to 90 minutes in duration depending on appointment type, and occur at a scheduled time agreed upon between you and the ISU Integrated Mental Health Clinic. You are expected to arrive on time and your session cannot be extended due to late arrival. If you need to cancel your appointment please leave a message on the clinic voicemail, (208) 373-1979, at least 24 hours before your scheduled session.

The ISU Integrated Mental Health Clinic is open when school is in session during the fall, spring, and summer semesters and is not staffed during school holidays. This may mean you will not be able to see your provider for one to four weeks between semesters. Your provider will work with you in advance to plan for these breaks and provide referrals if needed.

You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, or national origin. Your provider is a safe person to talk with about any of these topics.

The ISU Integrated Mental Health Clinic is a teaching facility made up of licensed psychiatric nurse practitioners, psychiatric pharmacists, licensed clinical psychologists, and post-doctoral students working towards their master's degrees in prescribing psychology. As student's progress or graduate they will no longer continue to work in the clinic. Student providers will inform you in advance of any changes in their availability. If the need arises for the student provider to transition out of the clinic, they will work closely with you and their supervisor to create an individualized plan to support you.

_____ **Risks and Benefits:** There is a possibility of risk with any treatment, including medication and counseling. Counseling may involve the risk of remembering unpleasant events; arouse strong emotional responses; and impact client's relationships. Medications can produce unwanted adverse effects, and in some cases impact medical comorbidities. The risk and benefit of treatment is always considered by your provider, and he/she will consult with you and/or any of your other healthcare providers to determine the best course of treatment. Speaking honestly about your experiences with any treatments you receive will increase your provider's ability to assist you.

_____ **Limitations of Service:** The student providers at the ISU Integrated Mental Health Clinic are not licensed prescribers. All are students of ISU allied health programs working under the supervision of licensed medical professionals. Limitations of clinic personnel may include inability to diagnose, provide insurance billing, evaluate for parental fitness and custody, court or legally mandated services, or offer counseling pertaining to criminal proceedings.

_____ **Payment and Billing:** Payment is due at the beginning of each appointment and your provider is unable to see you without payment. If you are unable to afford the fee please discuss this situation with your provider and we may be able to provide sliding scale, or pro bono services, on a limited basis. You may not carry forward a credit; please pay for each counseling session individually.

_____ **Crisis Communication:** The ISU Integrated Mental Health Clinic can be called during limited business hours Monday through Wednesday at (208) 373-1979. Please note that this phone line will not be available during University holidays and/or closures. We are unable to provide emergency services. If you have an emergency, please call 911 or go to your nearest emergency room.

_____ **Electronic Communication:** The ISU Integrated Mental Health Clinic staff will not interact with clients via social media. Any social media presence by ISU Integrated Mental Health or staff members will not be continuously monitored and will not be utilized as a means of communication between client and clinician. In addition, ISU Integrated Mental Health staff will not utilize text messaging, instant messaging, Snapchat, or similar communications to interact with students. Students/providers may opt to be contacted by a voice phone call or, by client request, email. Email will only be used for scheduling purposes and not as a form of communication about therapeutic issues or for crisis intervention. Staff do not monitor email outside of regular business hours and may not check email consistently throughout the day.

_____ **School Environment:** The ISU Integrated Mental Health Clinic shares a building with Renaissance High School and the West Ada School District Offices. The school is required to conduct periodic fire drills and lock down procedure drills. In the event of a fire drill an alarm will sound and you will be required to exit the building and gather at the designated assembly location in the parking lot. You will be permitted to return to the building after a short period. In order to maintain confidentiality your student counselor will not discuss any issues outside of the session. In the event of a lock down drill you will be asked to stay in the counseling room until the all clear is given. In the event of a real lock down emergency you are asked to use good judgement and either remain in the locked suite or quickly exit should you feel this is the safest course of action.

Due to the clinic's proximity to Renaissance High School, ISU Meridian Counseling Clinic is unable to offer services to registered sex offenders or individuals with a history of violence. Additionally, guns and weapons are not permitted on the premises.

I have read and understand the ISU Integrated Mental Health Clinic Informed Consent.

Signature of Client

Date

I, the provider, have discussed the issues above with the client. My observations of this client's behaviors and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent.

Signature of Provider

Date



Telehealth Patient Consent Form

Purpose: The purpose of this form is to get consent for participation in a model of healthcare called telehealth. Telehealth involves the use of electronic communications to enable healthcare providers to share individual patient medical information for the purpose of improving patient care and providing care at a location separate from the provider. ISU will be using ZOOM remote technology to evaluate/re-evaluate virtually, to help manage your hearing needs. Also, our providers will determine whether you have a condition that requires in-office treatment.

What is a Telehealth Consultation: Telehealth is a tool used to help people who cannot go to a healthcare provider's office to receive an examination or consultation. Telehealth uses electronic records including your health history and other information. Your consultation with the provider and these records will be used to address your health concerns or recommend further treatment.

What are the Risks, Benefits, and Alternatives?: The benefits of telehealth include having access to a healthcare provider without travelling to a provider's office or clinic. A potential risk of telehealth is that a face-to-face consultation with a healthcare provider may still be necessary after the telehealth appointment. At any time during the consultation, you may choose to end the session and seek care in our clinic based on availability.

Confidentiality: Current federal and Idaho laws about confidentiality apply to the information used or disclosed during your telehealth consultation. In rare cases, some of your records may unintentionally become available to people not connected with the consultation. You will be provided with a separate document, which describes how your private information will be handled. This is known as the "Notice of Privacy Practices."

Rights: You may choose not to participate in a telehealth consultation at any time before and/or during the consultation. If you decide not to participate it will not affect your right to future care or treatment. You have the option to seek consultation or treatment in an office at any time before or after the telehealth consultation.

Fees associated with Telehealth: If you have insurance that covers your services via telehealth, we will submit your telehealth visit to your insurance for processing. If your services are considered non-covered, there may be a fee associated with the visit that will be your responsibility.

I have read and understand the information provided above regarding telehealth, have discussed it with my provider, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth and billing that may be related to my telehealth consultation.

Patient/Guardian Signature

Date



Dear Patients and/or Guardians:

We are excited to announce that we now have a new practice management system that offers our patients some new features. We now have the ability to send you an appointment reminder via email or text messaging.

Email Reminders Yes No Email: _____

Text Reminders Yes No Carrier*: _____ Cell No. _____

* (Verizon, AT&T, etc.)

Consent for Communication of Healthcare Information by Email and Text Messaging

The clinic cannot guarantee the confidentiality or integrity of email or text messages and cannot be held liable for such breaches.

Risks of using email and text messaging:

- Due to the nature of the technology, unauthorized individuals may be able to intercept, read and modify email and text messages used to correspond regarding your health treatment.
- Messages can be misaddressed, misdelivered, forwarded or delivery can simply fail to occur.
- Service providers have the right to access and archive messages transmitted through their systems.
- Friends and family members may see and forward your messages, if you do not restrict their access.

Best practices when using email and text messaging:

- Minimize the amount of sensitive data that is contained in the message
- Do not use for urgent or emergency communications
- Maintain control of the personal accounts used for messaging
- If you do not receive a response in a reasonable amount of time, call the clinic to confirm receipt.

Check "one" box below:

I acknowledge that I have read and fully understand the risks and best practices regarding the use of email and text messaging for communications with the clinic, and consent to the use of such email and text messaging for **reminders of appointments only.**

I do not consent to the use of email and text messaging for communicating with the clinic for any purpose.

Patient/Guardian Signature

Date



**Authorization to Obtain
Emergency Medical Treatment**

I authorize the ISU Integrated Mental Health Clinic to obtain emergency medical treatment at any hospital for the individual listed below. I agree to be fully responsible for any costs related to the said treatment, and to hold harmless Idaho State University of any such costs.

Print Name of Patient

*Signature of Patient or Personal
Representative*

Date

Authority of Personal Representative to Sign for Patient (check one):

Parent Guardian Power of Attorney Other: _____



Acknowledgement of Receipt of Notice of Privacy Practices

The privacy of your protected health information is important to us. We have provided you with a copy of our Notice of Privacy Practices. It describes how your health information will be handled in various situations. We ask that you sign this form to acknowledge you received a copy of our Notice of Privacy Practices.

I acknowledge that I have received a copy of the ISU Integrated Mental Health Notice of Privacy Practices.

Print Name of Patient or Personal Representative

Date

Signature of Patient or Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

- Parent Guardian Power of Attorney Other:

Please Note: It is your right to refuse to sign this Acknowledgement.

For Office Use Only

We have made a good faith effort in attempting to obtain written acknowledgement of receipt of the Notice of Privacy Practices.

- 1. Does the patient have a copy of the Notice of Private Practices? Yes No
2. If you answered "No" above, please explain why the patient did not sign acknowledgment form:
Patient/individual refused to sign (Date of Refusal).
Communication barriers prohibited obtaining an acknowledgement.
Legal representative not available.
Patient bypassed registration.
An emergency situation prevented ISU from obtaining an acknowledgement.
Other:

Completed By: Signature Date

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY, SIGN THE ACKNOWLEDGEMENT OF RECEIPT, AND GIVE TO THE RECEPTIONIST.

Protecting Your Personal and Health Information

Our clinic is committed to protecting the privacy of its patients' personal and health information. Applicable Federal and State laws require us to maintain the privacy of our patients' personal and health information. This Notice explains our clinic's privacy practices, our legal duties, and your rights concerning your personal and health information. In this Notice, your personal and health information is referred to as "health information" and includes your name, age, address, income or other financial information. We follow the privacy practices described in this Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until replaced.

How We Protect Your Health Information

We protect your health information by:

- Treating all of your health information that we collect as confidential.
- Stating confidentiality policies and practices in our medical and clinical staff handbooks as well as disciplinary measure for privacy violations.
- Restricting access to your health information only to those medical and clinical staff who need to know your health information in order to provide our services to you.
- Only disclosing your health information that is necessary for an outside service company to perform its function on our behalf, and the company has by contract agreed to protect and maintain the confidentiality of your health information.
- Maintaining physical, electronic, and procedural safeguards to comply with federal and state regulations guarding your health information.

Uses and Disclosures of Your Health Information

We will use and disclose health information about you for treatment, payment and health care operations. For example:

- **Treatment:** We may provide another physician or subsequent healthcare provider who is treating you with copies of various reports of your health information that should assist him or her with your treatment.
- **Payment:** We may use and disclose your health information to obtain payment for services we provide to you.
- **Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training and educational programs, accreditation, certification, licensing, or credentialing activities.
- **Your Authorization:** In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

- **To Your Family and Friends:** We must disclose your health to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
- **Persons Involved in Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.
- **Marketing Health-Related Services:** We will not use your health information for marketing without a written authorization from you.
- **Required by Law:** We may use or disclose your health information when we are required to do so by law, including, but not limited to, court or administrative orders, subpoenas, discovery requests, or other lawful process.
- **Abuse or Neglect:** We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
- **National Security:** We may disclose to military authorities the health information of Armed forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose health information to a correctional institution or law enforcement official having lawful custody of protected health information of an inmate or patient under certain circumstances.
- **Appointment Reminders:** We may also use health information about you to call, leave a voice message, text, email, or send a postcard or letter to you as a reminder about an appointment.
- **Research:** Under certain limited circumstances, we may use and disclose health information about you for research purposes. All research projects, however, are subject to a special approval process.

Rights You Have Regarding the Use and Disclosure of Your Health Information

You have the right to request all of the following:

- **Access to Your Health Information:** You have the right to request a copy of your health information. A nominal fee may be charged for providing copies. However, this right does not include the following types of records: psychotherapy notes; records compiled in reasonable anticipation of a court action or administrative action or proceeding; and protected health information whose release is prohibited by federal or state laws. Access to your records may also be limited if it is determined that by providing the information it could possibly be harmful to you or another person. If access is limited for this reason, you have a right to request a review of that decision.
- **Amendment:** You have the right to request in writing an amendment to your health information. The request must identify which information is incorrect and an explanation of why you think it should be amended. If the request is denied, a written explanation stating why will be provided to you. You may also make a statement disagreeing with the denial which will be added to the information of the original request. If your original request is approved, we will make reasonable effort to include the amended information in future disclosures. (Amending a record does not mean that any portion of your health information will be deleted.)
- **Accounting or Disclosures:** If your health information is disclosed for any reason other than treatment, payment, or operation, you have the right to an accounting for each disclosure of the previous six (6) years. The accounting will include the date, name of person or entity, description of the information disclosed, the reason for disclosure, and other applicable information. If more than one (1) accounting is requested in a twelve (12) month period, a reasonable fee may be charged.

- **Restriction Requests:** You have the right to request that the clinic place additional restrictions on uses and disclosures of your health information. We may not be able to accept your request, but if we do, we will uphold the restriction unless it is an emergency.
- **Confidential Communication:** You have the right to request that communication regarding your health information be done in an alternate way or be sent to an alternate location.
- **Electronic Notice:** If you received this notice by accessing a web site or by email, you are also entitled to have a paper copy which is available by request from the clinic or department.

Changes to this Notice

We reserve the right to change our privacy practices and terms of this Notice at any time, as permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make such changes, we will update this Notice and post the changes in the waiting room or lobby of the facility. You may also request a copy of the Notice at any time.

Questions and Complaints

For questions regarding this notice or our privacy practices, please contact our office.

If you are concerned that your privacy rights may have been violated, you may contact either of the people listed below to make a complaint. You may also make a written complaint to the U.S. Department of Health and Human Services whose address can be provided upon request.

If you choose to make a complaint with us or the U.S. Department of Health and Human Services, we will not retaliate in any way.

ISU Clinic Operations: Cindy Rock, Clinics Director of Operations
1311 E. Central Dr.
Meridian, ID 83642
(208) 373-1743
cindyrock@isu.edu

ISU Privacy Officer: HIPAA Privacy & Security Officer
Office of General Counsel
921 S. 8th Ave, Stop 8410
Pocatello, ID 83209
(208) 282-3234
HIPAA@health.isu.edu



Patient Authorization to Release Protected Health Information (PHI)

Patient Name: _____ DOB: _____
Address: _____ Phone No.: _____

I authorize ISU's Integrated Mental Health Clinic and any of their affiliated entities, employees, agents, or associated health care practitioners to use or disclose the patient's protected health information (PHI) as described below:

- 1. I authorize the use and disclosure of my PHI to be RELEASED to the following entity:

Name: _____
Address: _____
Phone: _____ Fax: _____

Records from: _____ to: _____

Records to be released: Other: _____

- Evaluation Reports, X-Ray Reports, Laboratory Tests / Reports, Progress Notes, X-Ray Films, Consultation Reports, Discharge Summary, Pathology Reports, History and Physical Exam

- 2. I authorize the use and disclosure of my PHI to be OBTAINED from the following entity:

Name: _____
Address: _____
Phone: _____ Fax: _____

Records from: _____ to: _____

Records to be released: Other: _____

- Evaluation Reports, X-Ray Reports, Laboratory Tests / Reports, Progress Notes, X-Ray Films, Consultation Reports, Discharge Summary, Pathology Reports, History and Physical Exam

If the information includes records or information from another health care provider or entity, that information:
SHOULD or SHOULD NOT be released under this Authorization. This Authorization applies only to the information indicated above. Additional information shall require another Authorization.

- 3. The disclosure is for the following purpose (check one and complete as needed).

Patient Request, Continuity of Care, Legal, Other: _____

I acknowledge that the information to be released MAY INCLUDE information protected by federal and state laws.

The ISU Integrated Mental Health Clinic will send information ONLY to the above address or fax number. Any disclosure of the patient's PHI to another person or entity will require another authorization.

This Authorization is valid for one (1) year from the date set forth below. It may be revoked at any time in writing to ISU's Privacy Officer below prior to the expiration of such 90-day period. Revocation of this authorization shall not affect releases to the revocation.

ISU Privacy Officer: ISU General Counsel
921 S. 8th Avenue, Stop 8410
Pocatello, ID 83209
(208) 282-3022
Email: HIPAA@health.isu.edu

I may refuse to sign this authorization, which will not affect my treatment or payment for health care at the ISU Integrated Mental Health Clinic.

After your PHI (medical records) are released by your authorization, the possibility exists that your PHI will no longer be subject to the protection of federal privacy regulations and may be re-disclosed by the recipient.

I certify that I have the authority to approve the requested release of information and sign this authorization.

Print Name of Patient

Signature of Patient or Personal Representative

Date

Authority of Personal Representative to Sign for Patient (check one):

Parent Guardian Power of Attorney Other: _____