MOUNTAIN LAKE SERVICES
Consent Form for Treatment, Payment & Operations
Uses & Disclosures

Name: _____

We understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your consent before we may use or disclose your protected health information for the purposes described below. This form provides consent and helps us make sure that you are properly informed of how this information will be used or disclosed. Please read the information below carefully before signing this form.

USE AND DISCLOSURE COVERED BY THIS CONSENT

A representative of **Mountain Lake Services** must answer these questions completely before providing this consent form to you. You or your personal representative should read the descriptions below before signing this form.

Who will disclose the information?

Mountain Lake Services will disclose information as necessary for Treatment, Payment & Operations (TPO) in accordance with, and as required by, law.

Who will use and/or receive the information?

Mountain Lake Services and its employees, and other organizations who require this information for TPO, will receive personal health information. This includes, but is not limited to, business associates, billing vendors, health care providers, Office for People with Developmental Disabilities, and Consumer Advisory Board representatives. Unless you object, we will share your health information with family members, relatives or a close personal friend who is involved in your care or payment for your care.

What information will be used or disclosed?

Mountain Lake Services may use and disclose personal health information for the following:

- ❑ **Treatment**: *To provide you with treatment and services.* We may disclose health/clinical information about you to: doctors, nurses, psychologists, social workers, qualified mental retardation professionals (QIDPs), counselors, your service coordinator, other agency personnel, volunteers or interns who provide you with care, to other providers outside of the agency who provide you with services identified in your Individualized Services Plan, or to other providers to obtain new services for you.
- ❑ **Payment**: *To bill and collect payment* from either: you, a third party, an insurance company, Medicare or Medicaid, or other government agencies.
- ❑ **Health Care Operations:** For *agency administrative operations*, such as: for quality improvement to review our treatment services; to obtain legal services; to conduct fiscal audits; and for fraud abuse and detection.
- ❑ **Other reasons allowed by law.** Besides disclosures for treatment, payment, and health care operations, Our agency may also use health information about you without your permission *when allowed by law.* Some examples are: when we are required to do so by federal or state law; for health oversight activities (including audits, investigations, surveys and inspections); for law enforcement purposes; and to prevent or lessen a serious and imminent threat to your health and safety or to someone else.

What is the purpose of the use or disclosure?

Mountain Lake Services will disclose information for the purpose of treatment, billing and operations or to disclose personal health information to a third party specified by you.

When will this authorization expire?

This consent form expires at your request or automatically when services are no longer being provided to you by Mountain Lake Services.

SPECIFIC UNDERSTANDINGS

By signing this consent form, you authorize the use or disclosure of your protected health information as described above. This information may be redisclosed if the recipient(s) described on this form is not required by law to protect the privacy of the information, and in that event such information may no longer be protected by the federal HIPAA privacy regulations.

You have a right to refuse to sign this consent. Your health care, the payment for your health care, and your health care benefits will not be affected if you do not sign this form.

You have a right to see and copy the information described on this consent form in accordance with agency policies. You also have a right to receive a copy of this form after you have signed it.

If you sign this consent, you will have the right to revoke it at any time, except to the extent that the agency has already taken action based upon your authorization. To revoke this authorization, please write to the Privacy Officer.

SIGNATURE

Individual Name: _____ **Date:** _____

Signature: _____ **Relationship to Individual:** _____