**HIPAA-State of Alaska Department of Health and Social Services**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND HOW YOU CAN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I understand that information collected about you and your health is personal. Protecting your health care information is one of my most important responsibilities. You have the right to discuss with your provider concerns about how your health care information is shared. By Alaska Law:

1. I will protect your health care information from others who do not need it.  
2. You may ask that certain health care information remains private.  
3. I review documentation to ensure quality of care legal compliance.  
4. You may ask in writing to receive a copy of your health care information.  
5. You may ask in writing that I correct or add to inaccurate or incomplete documents.  
6. You may ask that corrected documents be sent to others with a Release of Authorization (ROI) form.  
7. You may ask for a list of where I sent your health care information.

Please note that I must report the following:  
a. Knowledge of contagious diseases.  
b. Minimally necessary documentation to the police when required by law or a court order.  
c. Minimally necessary documentation to the government for auditing purposes.  
d. Minimally necessary documentation to a provider or insurance company if needed to confirm service engagement.  
e. Minimally necessary documentation to workers compensation for work related injuries.  
f. In response to confirmation of abuse or neglect of children or vulnerable adults.

**Consent for Telehealth Counseling**

I have requested to engage in telehealth counseling. My provider has explained to me how technology will be used and that the remote platform it is not be the same as a direct client/provider visit due to the fact that I will not be in the same room as my provider. I understand that a telehealth service has potential benefits including easier access to care and the convenience of meeting from a location of my choosing. I also understand there are potential risks to this technology, including interruptions and technical difficulties. I understand that my provider or I can discontinue the telehealth session if connectivity is problematic. I have I had the opportunity to ask questions in regard to this format. My questions have been answered and the risks, benefits and any alternatives have been discussed with me in a manner that I understand.

By signing this document, I acknowledge:  
1. That telehealth is NOT an Emergency Service and in the event of an emergency I will call 911.  
2. That my provider does not have access to all of the information to resolve technical difficulties.  
3. That I will not share my telehealth link with anyone unauthorized to attend.

**By My Signature Below I Affirm Receipt of Notice of Privacy Practices and Have Read, Understand and Agree To The Terms AND I Agree to The Terms Contained in Kachemak Counseling Practice Policy.**

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Signature Date

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