ALL NEW CLIENTS MUST FILL OUT ALL PAGES OF THIS CONFIDENTIAL FORM REGARDLESS OF THE TYPE OF TREATMENT YOU ARE INITIALLY SEEKING. PLEASE READ VERY CAREFULLY AND SIGN AND INITIAL ALL PLACES REQUESTED. PLEASE KEEP A COPY FOR YOUR OWN RECORDS BEFORE SUBMITTING.

Your Name: **Date:**

Address: **Email:**

Please circle the treatment you are seeking today: Individual Counseling Couples Counseling

Brennan Healing Science Energy Treatment

IF YOU ARE HERE FOR COUPLES COUNSELING, PLEASE LIST YOUR PARTNERS NAME AND THE CELL AND HOME PHONE INFORMATION IN THE SPACE PROVIDED DIRECTLY UNDER YOUR PHONE #'S.

Partners name:

Your phone #: **May I call you there?**

Your partner's # **May I call them there?**

Your cell # **May I call you there?** **Text you?**

Your Partner's cell # **May I call them there?** **Text them?**

YOUR EMERGENCY CONTACT: NAME: **PHONE:**

YOUR RELATIONSHIP STATUS: PLEASE CIRCLE: MARRIED SINGLE LIVING TOGETHER DIVORCED SEPARATED WIDOWED

Your reason for today's visit: **Date of onset:**

Current/previous treatment for above:

Your intention/ the one thing you would like to gain from today's visit:

Current Medications:

Current Complementary Therapies/ Supplements:

What do you do for Self-Care: Please list: exercise routines, meditation, hobbies:

Eating habits/ Diet/ Water intake/ caffeine/ alcohol/ cigarettes:

Please list any, and all symptoms or diseases you have had, or currently have, and indicate:

C for Current; P for Past; CH for Chronic. This includes Emotional, Allergies, Neurological, MusculoSkeletal, Cardiovascular, Respiratory, Digestive, Urinary, and Reproductive.

THE PURPOSE OF THIS INQUIRY IS FOR YOU TO BEGIN TO MAKE THE BODY-MIND-EMOTIONAL CONNECTION AND FOR YOUR THERAPIST/HEALER TO GET MORE UNDERSTANDING OF YOU ON ALL LEVELS. IT WILL ALSO HELP HER TO CHOOSE THERAPEUTIC AND ENERGETIC TECHNIQUES BEST SUITED FOR YOU, AND TO ASSIST YOU IN BUILDING YOUR TREATMENT TEAM FOR SELF-CARE. PLEASE USE THE BLANK SPACE BELOW TO LIST:

==

Please list any traumatic or life -threatening events that occurred in your life and when they happened:

What do you hope for and what are your Intentions for this healing/ or therapy session today, and long term? In simple words, if you could get one thing out of this session, what would it be?

Is there anything else you want to share or want me to know?

Thank you for selecting me as your therapist. This document is designed to inform you of my background and to ensure you understand our professional relationship.

PROFESSIONAL QUALIFICATIONS: Master's Degree in Counseling Psychology. Licensed by the State of Florida as a Licensed Mental Health Counselor, License #MH000312. Brennan Healing Science Practitioner.

THEORETICAL APPROACH: My theoretical approach is a combination of Jungian, Family Constellation, Mind-Body-Spirit integration, Energy Consciousness, Meditation techniques. Education on particular conditions, and an eclectic blend of techniques which I've gained from my extensive training, and 40 years of experience including Substance abuse treatment, Out- patient Counseling, Employee Assistance Programs, Hospice Bereavement work, Private Practice, and Brennan Healing Science.

Here are some aspects of how I view and practice therapy and healing:

Treatment involves your active involvement as well as your intention to change your thoughts, feelings and behaviors. You will be asked to work both in and out of the counseling/healing sessions. In working with you we will need to specify the goals, and benefits of treatment. Other parameters that will be agreed upon, include : cost of treatment, time commitment, and canceling/rescheduling requirements of the appointments. Periodic reviews of the counseling/healing process will take place and if necessary, restructuring of the treatment plan, goals, and methods will take place as the process unfolds.

RISKS AND BENEFITS OF COUNSELING: It is important for you to understand that with change, comes some risks and benefits. The risks may show up within relationships with family first, and possibly friends or other relationships. When you begin to make changes within yourself, the dynamics of how you choose to be with others will also change. This may cause some disturbance with others. Other risks include you feeling worse before you begin to feel better about your treatment issues. The benefits with change are : growth, heightened self-respect, and sense of accomplishment as you reach your goals. Relationships improve as you set your boundaries and attract new people who respect those boundaries. Fully informing you, the client, of a diagnosis, may initially pose a risk to your self-image, however the validation, veracity, support, and information provided by your counselor, promotes self-confidence and autonomy. This will ultimately promote your long- term progress.

COUNSELING EXPERIENCE: My counseling experience entails working with numerous life issues including depression, grief, PTSD, all phases of workplace issues, individual, group, and relationship counseling, and more during my 40 years of experience as a therapist.

CONFIDENTIALITY: The privacy and confidentiality of our sessions and my records is a privilege of yours and is protected by state law and my profession's ethical principles, with the following exceptions: 1) When an assessment is made that the client intends to be harmful to self or others, 2) court orders to release information where a judge has signed the order, 3) client signs written release consents, and 4) reporting of child or elder abuse or neglect. Otherwise, confidentiality will be

kept about your treatment, diagnosis, and history, or even that you are a client without your full knowledge and a signed Release of Information form.

IN WORKING WITH A CHILD OR ADOLESCENT: It is important that the parents understand that confidentiality with their children also stands unless they are putting themselves in a position of danger with behaviors such as suicidal ideation and gestures, self-injurious behaviors, dangerous drug use, meeting adult strangers on the internet, running away, and any other behavior deemed dangerous or life threatening. If the child or elder reports any form of abuse from the caregivers, it is a requirement for this therapist to make a report to the Department of Child and Family Services. You will be notified of such report from this therapist. In working with a minor for Brennan Healing Science, the parent must sign the Consent to Treatment Forms, and must be present in the healing room, or in the virtual session during the entire session.

IN WORKING WITH COUPLES OR FAMILY MEMBERS: This therapist cannot guarantee that confidentiality will be maintained between the members of the couple or family. If there is a request for a release of information for a couple or family, all members must sign the release before anything will be afforded the party requesting documentation. Couples will be asked to sign full disclosure to this therapist where no secrets can be maintained that work against the counseling goals established in therapy.

CELL/COMPUTER CONTACT: If you choose to contact me and discuss your issues on a cell phone, text messaging format, or on the computer, this therapist cannot guarantee full confidentiality due to illegal and unprotected access to this material. _________INITIAL

CONSULTATION AND INSTRUCTION: Your case may be discussed in a Peer Consultation Clinical Group in order to review treatment approach and receive valued feedback from clinical peers. Your name and identifiable information will not be disclosed with this group.

YOUR INFORMATION, YOUR RIGHTS, OUR RESPONSIBILITIES: This notice describes how medical information about you may be used and disclosed and how you can access this information. PLEASE REVIEW IT CAREFULLY. Your Rights: You have the right to: get a copy of your paper mental health record, however, only if this clinician finds the information to cause no harm to the client. It is up to the discretion of this therapist to release any clinical notes on the client. If you come in for treatment as a couple or family, all members must sign a release first. YOU HAVE THE RIGHT TO REQUEST CONFIDENTIAL COMMUNICATION. You have the right to ask us to limit the information we share. YOU HAVE THE RIGHT TO GET A LIST OF THOSE WITH WHOM WE'VE SHARED YOUR INFORMATION. You have the right to get a copy of this privacy notice. You have the right to file a complaint if you believe your privacy rights have been violated. YOUR CHOICES: You have some choices in the way we use and share information in how we tell your family and friends, or others involved in your care, about your condition, only if you've signed a release of information or if there is an expression of harm to self or others. If you have a clear preference for how we share your information, tell us what you want us to do and we will follow your instructions.

OUR USES AND DISCLOSURES: We may use and share your information as we Treat you (sharing with other professionals who are treating you- with appropriate releases signed). Filing for insurance reimbursement (though not in the practice of Gail Lois Jaffe, P.A. as it is private pay), Complying with the law, responding to lawsuits and legal actions, with appropriate releases of information signed by appropriate parties.

YOUR REQUEST FOR CONFIDENTIAL COMMUNICATIONS: You can ask us to contact you in a specific way (for example: hone, office or cell phone) or to send mail to a different address.

______(initials) I am comfortable with you contacting me by cell phone or text.

______(initials) I am comfortable with you contacting me by the phone number given to therapist and leaving a voice message that is confirming or changing appointment times.

_____(initials) I am comfortable with you sending me mail with confidential marked on the envelope to my home address as needed.

CHOOSE SOMEONE TO ACT FOR YOU: If you have given someone medical power of attorney, or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

OUR RESPONSIBILITIES: We are required by law to maintain the privacy and security of your protected mental health information. We must follow the duties and privacy practices described in this notice and give you a copy of it (or give you online access to it). We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can you may change your mind at any time, and it is your responsibility to let us know in writing. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

RECORD MAINTENANCE: Your records will be kept in written format under private coding for the next seven years after you complete your therapy.

EMERGENCIES: Please note: I AM NOT AVAILABLE 24 HOURS A DAY. I will be available to answer calls throughout the week. If I do not answer at the time of your call, I will return your call as soon as possible. I am unable to provide emergency services, so IF YOU HAVE AN EMERGENCY, PLEASE CALL 911.

Phone calls are not charged unless they exceed 15 minutes. If you have more than one call between the sessions, you will incur charges prorated to the length of the combined calls. If your call is between 15-30 minutes you will be charged on a prorated basis relative to the hourly fee originally agreed upon. It is preferred that you call between the hours of 10:00am and 8:00pm. If you are experiencing an emergency outside of those times, please contact 911 for immediate assistance. I ask you to use texts and emails judiciously to give me brief, concise information regarding scheduling, cancellations, or if I specifically asked you to give me a progress report after an initial healing. It is my experience that lengthy communications are discouraged as tone or content can be misinterpreted

and are not in the best interest of the therapeutic relationship. Better to wait until the next appointment to discuss issues in person. _____ (initial here)

SIGNATURE PAGE FOR CONSENT FOR TREATMENT

In signing the below, I understand and agree with all the conditions of the disclosure statement and I give Gail Lois Jaffe, LMHC, consent to treat me.

______________________________________	__________________________________
Therapist(witness) Signature/ Date	**Client's Signature/Date**

FOR COUNSELING TO BE EFFETIVE AND PROVIDE AN ENVIRONMENT IN WHICH THE CLIENT FEELS FREE TO SHARE CONCERNS, THE COUNSELOR MUST BE ABLE TO ASSURE CLIENTS THAT PERSONAL INFORMATION WILL BE KEPT CONFIDENTIAL. COUNSELORS ACT IN THE BEST INTEREST OF CLIENTS AND TAKE MEASURES TO SAFEGUARD CONDIDENTIALITY. RECORDING OF ANY SESSION(S) NEED ALLPARTY CONSENT. THIS GOES FOR IN-OFFICE SESSIONS, AS WELL AS VIRTUAL SESSIONS OF ANY VENUE. GAIL LOIS JAFFE P.A. DOES NOT UNDER ANY CIRCUMSTANCES AGREE TO RECORDING SESSIONS! THESE RULES APPLY TO COUNSELING AND ENERGY WORK TREATMENT.

Federal Law: State of Florida:

Florida's wiretapping law is a "two-party consent" law. Florida makes it a crime to intercept or record a "wire, oral, or electronic communication" in Florida, unless all parties of the communication give consent. IF YOU PLAN TO RECORD TELEPHONE CALLS OR IN-PERSON CONVERSATIONS, OR VIRTUAL SESSIONS(INCLUDING BY RECORDING VIDEO THAT CAPTURES SOUND), YOU SHOULD BE AWARE THAT THERE ARE FEDERAL AND STATE WIRETAPPING LAWS, THAT MAY LIMIT YOUR ABILITY TO DO SO. THESE LAWS NOT ONLY EXPOSE YOU TO THE RISK OF CRIMINAL PROSECUTION, BUT ALSO POTENTIALLY GIVE AN INJURED PARTY A CIVIL CLAIM FOR MONEY DAMAGES AGAINST THEM.

ANY RECORDINGS, WHICH ARE BROUGHT TO MY ATTENTION: THE PERSON(S) WILL BE PROSECUTED TO THE FULL EXTENT OF THE LAW. I ALSO AGREE TO TURN MY CELL PHONE OFF DURING THE COMPLETE DURATION OF MY SESSION.

I understand and agree to ALL the above terms: Sign below:

____	______________________________________
CLIENT'S SIGNATURE/DATE	**THERAPIST(WITNESS) SIGNATURE/DATE**

If applicable, I also give GAIL LOIS JAFFE consent to treat the following dependent(s) of which I am parent or legal guardian: NAME AND AGE OF CHILD/YOUTH:_________________________________

SIGNATURE OF PARENT/GUARDIAN AND DATE: ____

CLIENT INFORMATION, PROTOCOL, AND CONSENT TO TREATMENT

FOR BRENNAN HEALING SCIENCE ENERGY TREATMENTS, WHETHER IN-OFFICE, OR VIRTUAL

You have just read and completed the previous pages which have mostly focused on Counseling protocols and discussion. Although I am a Licensed Mental Health Counselor (LMHC) and I bring my years of experience as a Psychotherapist with me to each session, Energy Healing is a different approach. Although we do talk prior to the Energy work, it is a conversation that is based on Energy Consciousness, and is more holistic, spiritual and multidimensional in nature. Psychotherapy is a bit more behavioral, intellectual, and emotionally based. Of course, there are overlaps, and I use all my experience, compassion, and training in each session you will attend, whether it is talk therapy, or energy work. If you are curious about Energy work, even if that is not what you came to me for initially, please ask me any questions you want about the services I provide.

It is my professional protocol to have all my clients read and complete all pages of my paperwork regardless of the initial reason for seeing me. It doesn't mean we will be doing Energy sessions, but it means that you are educated as to all the tools I have available to offer to you, and then if you want to try it, you are ready.

I am a Barbara Brennan Healing Science Practitioner (BHSP), which means I have graduated from an intensive, extensive, 4- year program at the Barbara Brennan School of Healing (BBSH). After graduating, I obtained my Massage license (MA#78553), which means I have complied with the State of Florida rules for touch. The techniques that I use in Energy Healing, include a gentle placement of my hands on your joints and major energy centers of your body while you lay fully clothed on the massage table. The energy work is done through the Human Energy field which surrounds the body. It is equally as effective when done in virtual sessions, since it is done through Intention, and my training included long distance, remote healings, with consent of the client, to receive this awesome treatment in the comfort of your own home.

PROTOCOL: First we will go over your paperwork discussing your history, including medical, social, emotional, and focus on your present concern. You will be asked to state an Intention for what you hope to gain in your session. When this is established, and the talk portion has been completed, we will move to the massage table and do energy healing. If this is a virtual session, after our talk on the virtual venue, you will move to a comfortable, private place in your home where you can lay down and be near your computer so your healer can still see you and be in contact. When your healing is completed, you will be given a few minutes to relax and integrate your experience. You will then be invited to share BRIEFLY about your experience. Briefly is important—sharing sensations, or insights

without getting intellectual -just stay in the experience and let it settle in. Your healer may briefly share her observations if you request. It is important for you to observe the self-care suggestions outlined in that section and bring any concerns, questions, thoughts, and feelings that may arise (all normal part of the process) to your next healing session.

It is my experience that the BHS work clears and charges the energy field, removing energetic blocks that lead to dis-ease, and enhancing the body's natural healing capability. Many of my clients experience increased well-being and improvement in their overall condition , or their presenting complaint, and receive insight that may lead to better self-care: however I cannot promise these things as everyone is unique in their experience of this work.

I clearly and definitively state that I do NOT medically diagnose or prescribe treatment. If you have a physical injury or disease condition, I ask that you also be in the care of a licensed medical professional. In fact, I have made that a prerequisite for clients who had certain conditions, or if I felt they were jeopardizing their health by not being under medical treatment. I do not advise you to discontinue any medical treatment you may be receiving. My work is intended to be in harmony with any other healing work that you receive, including traditional medicine, alternative medicine, or any form of physical or psychological therapy. Having a healing team of your own choosing in place is an important aspect of our work together. Please feel free to discuss our work with your Physician, Nurse Practitioner. Chiropractor, Massage Therapist, Acupuncturist, yoga instructor, Dietician, or any others on your care team ____(initial here).

SELF-CARE is an extremely important part of your healing process. At all times, YOUR HEALING IS YOUR RESPONSIBILITY. If at any time during the session you are uncomfortable, it is your responsibility to inform me immediately. I recommend that you refrain from using alcoholic beverages, or any mood-altering substances for at least 24 hours following your session. FOR THE NEXT THREE DAYS POST HEALING: pay special attention to your self-care: drink lots of water, get rest, sleep, nourish yourself with healthy foods, stay away from toxic relationships and situations to the best of your ability. Notice any thoughts, feelings, insights, dreams, physical sensations, and anything that may surface for you, whether subtle or powerful. There is no right or wrong reaction—even if it feels like nothing is different, simply notice. I advise that you make note of all these things and share with me during your next session _____ (initial here).My approach to healing and personal transformation is holistic, focusing on you as a unique, complex, dynamic, being of body, mind and spirit. I offer to serve as a facilitator in your SELF-INITIATED process of healing and transformation. I am here as your committed listener and partner in the process. In the course of our work together we will explore areas that influence your state of well-being. We may address your health history, life stressors, belief systems, attitudes, your family and childhood history, diet, exercise, dreams, longings, and your experiences in relationships. This helps me understand you at a deeper level so that I can support you in the best way possible. I will be able to tell you where your energy is blocked

in your body and help you to release those blocks. I may suggest ideas for further self-healing, which you may implement if you choose to do so.

What you share with me is always kept confidential. I do, however, discuss clients, without mentioning their names with my professional supervisors or professional peers for the purpose of my continuing professional development, and so that you may receive the best treatment available.

SCHEDULING, PROTOCOL AND FEES MENU FOR ALL SERVICES OFFERED BY GAIL LOIS JAFFE

LENGTH OF SESSIONS AND PAYMENT: You will be assured that my services will be rendered in a professional manner consistent with accepted ethical standards of my profession.

INDIVIDUAL COUNSELING	**$150.00 per hour**
BRENNAN HEALING SCIENCE ENERGY TREATMENT (BHS)	**$150.00 per hour**
COUPLES COUNSELING, OR 2 FAMILY MEMBERS	**$200.00 per hour**

Fees are for in-office as well as virtual sessions. If you have never worked with me before and are seeing me virtually for the first time: I will give you an additional complementary 15 minutes added to your hour, for the first session only. I have been specially trained to be PRESENT to you so your virtual sessions feel like we are face to face.

If you are seeing me for the first time, and are seeking Energy Treatment (BHS), an extra 15 minutes is required, bringing the fee to $ 190.00. Subsequent one- hour sessions will be $150.00.

If you have already worked with me in psychotherapy sessions, your first BHS session is for one hour at $150.00. An Energy session is typically 10 minutes of talk to identify the area of work and Intention, with 45 minutes of healing, and 5 minutes of sharing/integration.

You may decide to split your session half talk, half energy, for a one- hour session it is still $150.00 for the hour, but therapist will hold the time boundary to one hour.

If you want to extend your combo talk-energy session to 1 hour& 15 minutes: $190.00

If you feel you need a longer session than an hour, you can choose to schedule more time in increments of 15 minutes. The fee will be prorated to $40 per additional 15 minutes for a $150 per hour service, and $50 per additional 15 minutes for a $200 per hour service.

PLEASE NOTE AND INQUIRE IF INTERESTED: After your initial session at the above listed fees, you have the option of purchasing a pre-paid 4-session package at a 10% discount. It is non-refundable, nontransferable, and is a convenient and economical way to ensure your commitment to your treatment. It applies to in-office and virtual treatments, Individual, couples, and Energy treatments.

You may prefer to set up a regular schedule for treatment, regardless of the modality you choose, especially at the beginning of your treatment to ensure consistency and momentum. There is never an obligation to continue treatment. If you need to reschedule an appointment, I would appreciate as

much notice as possible. I REQUIRE A MINIMUM OF 24 HOURS NOTICE FOR ALL CANCELLED APPOINTMENTS. I UNDERSTAND THAT I WILL BE CHARGED THE FULL AMOUNT FOR THE SESSION IF 24 HOURS NOTICE IS NOT GIVEN. -------------------(initial here).If you decide to DISCONTINUE TREATMENT ABRUPTLY, and without notice, I will call you not more than two (2) times to follow up over the two weeks following our last session. If you do not return my calls, I will close your file and note that you terminated treatment with this therapist/healer without notice or consultation. ______ (initial here) Please note: It is impossible to guarantee any specific result regarding your treatment goals, but together we will work to achieve the best possible results for you. Thank you.

ACKNOWLEDGEMENT, RELEASE, AND CONSENT TO RECEIVE SERVICES FROM GAIL LOIS JAFFE P.A.

BRENNAN HEALING SCIENCE PRACTITIONER FOR BRENNAN HEALING SCIENCE ENERGY TREATMENTS

In signing this Acknowledgement, Release, and Consent you agree that you have read and fully understood my methods and protocol and that I have answered all your questions regarding this treatment. You also agree that I may work with you in the manner described in the section on Brennan Healing Science Energy treatments. You also agree that you have downloaded and kept your copy of this form and can access again if needed, all pages of this protocol.

I ____ have listed all my known medical conditions and physical limitations, and I will inform Gail Lois Jaffe, P.A. of any changes to my health. I understand that Gail Lois Jaffe, P.A. does not diagnose any medical, physical, or mental disorder nor prescribe medications. I accept my responsibility in consulting a qualified physician for any physical diseases that I may have.

I agree that all services rendered to me are charged directly to me when I schedule my appointment online, or at the time of service in-office if that is agreed upon, and that I am responsible for payment. I agree to pay for all scheduled appointments that I am unable to keep unless I notify Gail 24 hours in advance. If I have pre-paid for a package and cancel without 24 hour notice, that session will be considered as used and will be deducted from the sessions remaining.

I hereby acknowledge that I have read the foregoing Consent for Treatment.

I am satisfied that I understand the nature of the treatments and freely choose to receive these treatments. I release Gail Lois Jaffe, P.A. from any claims of malpractice, non-disclosure, or lack of informed consent. I also assume any risks of the treatment whether presently contemplated, or hereinafter discovered.

PRINTED NAME:____DATE: ____________

**SIGNATURE:____

GAIL LOIS JAFFE, P.A.:____DATE:_____________

YOUR COPY

NOTICE OF PRIVACY PRACTICES- BRIEF VERSION

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. THIS IS YOUR COPY TO KEEP.

MY COMMITMENT TO YOUR PRIVACY:

MY PRACTICE IS DEDICATED TO MAINTAINING THE PRIVACY OF YOUR PERSONAL HEALTH INFORMATION AS PART OF PROVIDING PROFESSIONAL CARE. I AM ALSO REQUIRED BY LAW TO KEEP YOUR INFORMATION PRIVATE. THESE LAWS ARE COMPLICATED, BUT I MUST GIVE YOU THIS IMPORTANT INFORMATION. THIS PAMPHLET IS A SHORTER VERSION OF THE FULL, LEGALLY REQUIRED NPP WHICH YOU RECEIVED ALONG WITH THIS TO REFER TO IT FOR MORE INFORMATION. HOWEVER, I CAN'T COVER ALL POSSIBLE SITUATIONS SO PLEASE TALK TO ME ABOUT ANY QUESTIONS OR PROBLEMS.

I WILL USE THE INFORMATION ABOUT YOUR HEALTH WHICH I GET FROM YOU OR FROM OTHERS MAINLY TO PROVIDE YOU WITH TREATMENT, TO ARRAANGE PAYMENT FOR MY SERVICES, AND FOR SOME OTHER BUSINESS ACTIVITIES WHICH ARE CALLED, IN THE LAW, HEALTH CARE OPERATIONS. AFTER YOU HAVE READ THIS NPP I WILL ASK YOU TO SIGN A CONSENT FORM TO LET ME USE AND SHARE YOUR INFORMATION. IF YOU DO NOT CONSENT AND SIGN THIS FORM, I CANNOT TREAT YOU.

IF I OR YOU WANT TO USE OR DISCLOSE (SEND, SHARE, RELEASE) YOUR INFORMATION FOR ANY OTHER PURPOSES I WILL DISCUSS THIS WITH YOU AND ASK YOU TO SIGN AN AUTHORIZATION FORM TO ALLOW THIS.

OF COURSE, I WILL KEEP YOUR HEALTH INFORMATION PRIVATE BUT THERE ARE SOME INSTANCES WHEN THE LAW REQUIRES ME TO USE OR SHARE IT. FOR EXAMPLE:

1. WHEN THERE IS A SERIOUS THREAT TO YOUR HEALTH AND SAFETY OR THE HEALTH AND SAFETY OF ANOTHER INDIVIDUAL OR THE PUBLIC. I WILL ONLY SHARE INFORMATION WITH A PERSON OR ORGANIZATION THAT IS ABLE TO HELP PREVENT OR REDUCE THE THREAT.
2. SOME LAWSUITS AND LEGAL COURT PROCEEDINGS.
3. IF A LAW ENFORCEMENT OFFICIAL REQUIRES TO DO SO.
4. FOR WORKERS COMPENSATION AND SIMILAR BENEFIT PROGRAMS.

THERE ARE SOME OTHER SITUATIONS LIKE THESE BUT WHICH DO NOT HAPPEN VERY OFTEN. THEY ARE DESCRIBED IN THE LONGER VERSION OF THE NPP.