Sutton Place Behavioral Health, Inc.
Acknowledgement of Receipt of Notice of
Privacy Practices and Consent Form

I acknowledge the receipt of the Notice of Privacy Practices of Sutton Place Behavioral Health, Inc.

I consent to the use and the disclosure of protected health information about me for treatment, payment, and health care operations as described in the Notice of Privacy Practices.

This means that information about my health will be used by the staff of Sutton Place Behavioral Health, Inc. or disclosed to other people or organizations whenever needed to:

- ⇨ Provide treatment to me or arrange for treatment by another health care provider;
- ⇨ Arrange for payment for services to me;
- ⇨ Operate the business of Sutton Place Behavioral Health, Inc.; and
- ⇨ Enable other health care organizations provide treatment to me or pay for services to me to review the quality and appropriateness of care I receive and conduct other health care operations.

I understand that information disclosed pursuant to this consent may not be re-disclosed by the recipient of the information. Most health care providers and all health benefit plans are obligated to follow federal rules (42 CFR-Part 2) and state laws for protection of the privacy of your health information. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

A written and signed revocation may be submitted at any time, but Sutton Place Behavioral Health, Inc. shall not be held liable for any information released prior to its receipt. Your Authorization for Release of Information may be valid for:

- ⇨ A single disclosure;
- ⇨ 90 continuing days from the signature date;
- ⇨ The duration of your treatment from the signature date; or
- ⇨ One continuous year from the signature date.

You must check the correct box on your Authorization for Release of Information to designate your preference.

I am the person who is the subject of the health records that will be used or disclosed. I agree to the use and the disclosure of my health information as described in this consent.

_____ _____
Signature Date

I am the personal representative of the person who is the subject of the health records maintained by Sutton Place Behavioral Health, Inc. My relationship to that person is _____.
I agree to the use and the disclosure of the health information as described in this consent.

_____ _____
Signature of Personal Representative Date

(09-11-03)