Dr. Steven R. Silverstein

APPROVED CLINICAL SUPERVISOR, CERTIFIED CLINICAL SUPERVISOR
LICENSED PROFESSIONAL COUNSELOR, LICENSED CLINICAL ALCOHOL AND DRUG COUNSELOR

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HIPAA Privacy Authorization and Release Form

This form provides a client's informed authorization for use and disclosure of his/her protected health information, including personally identifiable information. This form is required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164 (HIPAA) to be completed, signed, and dated by the client prior to the use and disclosure of the client's protected health information, as described below. Attention Counselor/Student: Do NOT upload this form to Blackboard, WebEx Teams, or any similar platform used in connection with a Liberty University course. This form must be maintained securely by both the healthcare provider and the student named below. Remember to also give the client a copy for his/her records.

Section I – Authorization

I, ____ (client name), understand that my counselor is a graduate student in the master's degree in ______________________ program and that my counselor is providing my counseling session(s) as a required part of his/her practicum, internship, or externship course requirement for that program. I authorize Dr. Steven Silverstein and ____ (counselor/student) to video record all or part of my counseling session(s) ___________ through ___________ (semester dates) and to use and disclose the video recording, including my name and all of my protected health information contained in the video recording, to the counselor/student's practicum, internship, or externship course instructor and students in that course at Liberty University.

Section II – Extent of Authorization

I understand that the purpose of the video recording is for the above-named counselor/student to receive professional training and constructive feedback on his/her counseling skills to improve the quality of counseling services that I (and future clients of the counselor/student) receive. To be specific, once I complete and sign this form, I understand that the above-named counselor/student will upload the video recording of my counseling session(s) to Kaltura and/or WebEx Teams, both of which are password-protected platforms used by Liberty University for educational purposes. The video recording (and a written transcript of the video recording) will be disclosed to and used by the counselor/student's practicum, internship, or externship course instructor and the students in that course for educational and professional training purposes, including a course presentation, a case conceptualization, and a verbatim paper. I understand that my personally identifiable information (e.g., my name) will be redacted from the written transcript and other written assignments, but not redacted from the video recording. I further understand that neither the video recording nor any written assignment will be used for any other purpose or disclosed to any persons outside of the counselor/student's course, as described herein, without my additional written consent, except as permitted or required by law (see Section IV below).

Section III – ***Effective Period***

This HIPAA Privacy Authorization and Release Form is valid and remains in effect until the end of the counselor/student's practicum, internship, or externship course. I understand that the video recording and the written transcript will be deleted at that time. If there is a desire to keep either the video recording or the written transcript for a longer period of time, my additional written consent will be required before doing so.

Section IV – Acknowledgements and Disclosures

I understand that the above-named Site Director or Approved Site Supervisor and counselor/student, as well as the course instructor and students will be required to maintain the same confidentiality as that required by members of the counseling profession. However, I acknowledge that there are certain exceptions to such confidentiality that require disclosure even without my authorization. Such exceptions that may require disclosure include: (1) my threat or act of serious harm to myself or another, (2) my disclosure of abuse of a minor, an elder, or an incapacitated adult, and/or (3) the issuance of a lawful subpoena, search warrant, or judicial court order that requires disclosure. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that my revocation will not be effective to the extent that any person or entity has already acted on my authorization. In other words, a revocation of my authorization cannot be retroactive and it will become effective only when my written revocation is received and processed. A copy of the written revocation must be sent to the Client's Healthcare Provider and Liberty University (either of which can be filled out below or an additional address can be listed at the discretion of the client). My written revocation of this authorization must be sent to:

Dr. Steven Silverstein, ACS, LPC, LCADC, Alternatives in Counseling, Inc.

562 Bonnieville Road, Huntington Mills, PA 18622, drssilverstein@gmail.com

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be subject to or conditioned on whether I sign this authorization. I understand that my decision to sign this form, and therefore to release my protected health information, is completely voluntary. I understand that, although my information used and disclosed pursuant to this form will be kept confidential and only used as described above, such information may no longer be protected by state or federal law, including HIPAA. Moreover, even though the video recording and the written transcript of my counseling session(s) will be deleted, I understand that written assignments, feedback, reviews, and grades based on them may be education records of the counselor/student that are maintained by Liberty University beyond completion of the course described in Section III above. In such event, my personally identifiable information will not be part of any such education records. Section V – Agreement and Signature By signing below, I (or, if the client is a minor or is incapacitated, I on behalf of the client) agree that I have carefully read and fully understand all of this HIPAA Privacy Authorization and Release Form, and I voluntarily agree to release my (or the client's) protected health information, as described above.

____Date: ___________

Signature of Client (or Parent/Legal Guardian)

____ Date: ___________

Signature of Witness

Acknowledgement of Receipt of HIPAA Privacy Authorization and Release Form

I acknowledge that I received a copy of the above completed and signed HIPAA Privacy Authorization and Release Form from the above-named counselor/student and I agree to maintain a copy for my (or my entity's) records.

____ Date: ___________

Signature of Client (or Parent/Legal Guardian)

____ Date: ___________

Signature of Site Director / Approved Site Supervisor