

Lynda Phillips, LCMHC, NCC. New York license no: 007554-1 NCC no: 328939. NPI- 1750845285
Email: Lynda@PhillipsCounselingpc.com
Website: www.PhillipsMentalHealthCounselingPC.com
Telephone: 917-692-1459

Form 8: Outdoor Consent

Exercise therapy involves the delivery of therapeutic mental health services outside of the office setting. This may include walking on public streets, in public parks, or other non-confidential locations.

My Rights

I understand that the laws that protect the privacy and confidentiality of private health information also apply to exercise therapy and that all effort will be made to protect my privacy and confidentiality. However, I also understand that by choosing to conduct my therapy session outdoors, I am allowing for the possibility that these rights may be compromised. I have the right to withhold or withdraw my consent to the use of exercise therapy during my care at any time. I understand that, in this event, Lynda Phillips will work with me to find an alternative form of care.

I understand that all rules and regulations which apply to the practice of clinical mental health therapy in the state of New York also apply to exercise therapy.

My Responsibilities

I will inform Lynda Phillips if any other person can hear or see any part of our session, or if I have concerns about this, as the course proceeds. Lynda Phillips will inform me if she has concerns that any other person can hear or see any part of our session as the session proceeds.

Patient Consent to Services out of the Office

I have read and understood the information provided above regarding mental health therapy outside of the office, I have discussed it with Lynda Phillips, of Phillips Mental Health Counseling PC and all of my questions have been answered to my satisfaction. By signing below, I am waiving my HIPAA privacy rights. I at this moment give my informed consent to the use of mental health counseling outside of the office setting.

Client printed name: _____.

Client signature: _____.

(Or person authorized to sign for patient)

Date: _____.