Resolution Services
Office of Vivian Patton
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Phone# (907)770-7769 Fax# (907)770-7634

As a client at our clinic, you have the right to the following:

1. Be informed of your rights verbally and in writing.
2. Give informed consent acknowledging your permission for us to provide service.
3. Receive prompt and adequate services and refuse services that you do not want.
4. Receive written information about fees, payment methods, co-payment, length and duration of sessions and services.
5. Receive complete and accurate information about your service plan, goals, methods, potential risks, and benefits and progress.
6. Receive information about the professional capabilities and limitations of any counselor(s) involved in your services.
7. Be free from audio or video recording without informed consent.
8. Have the confidentiality of your services and services records protected. Information regarding your services will not be disclosed to any person or agency without your written permission except under circumstances where the law requires such information to be disclosed. You have the right to know the limits of confidentiality and the situations in which the counselor/agency is legally required to disclose information.
9. Have access to information in your services records:
   a. With the approval of the clinic director during your treatment.
   b. To have information forwarded to a new provider following your services at this facility.
   c. To challenge the accuracy, completeness, timeliness, and/or relevance of information in your record, and the right to have factual errors corrected and alternative interpretations added.
10. File a grievance if your rights have been denied or limited. You can initiate a complaint either verbally or in writing to the grievance officer. You have the right to receive information about the grievance procedure in writing.

Client Confidentiality

Resolution Services has a commitment to keeping the information you provide and your clinical record confidential. Beyond our commitment to Ethical Standards, HIPAA and state law require it. You can give permission to our clinic in writing if you wish your information to be shared with specific persons outside our agency. There are exceptions when we can/must release information without your written permission. Your clinical information will be released without your written consent if: (1) it is necessary to protect you or someone else from imminent physical harm; (2) we receive a valid court order or subpoena that mandates we release your information; or (3) you are reporting abuse of children, the elderly, or persons with disabilities.

Clinicians within the agency may, at times, consult with each other regarding your treatment in order to provide you with the best possible services to meet your needs.

If your child is in treatment with our facility and is a minor, we ask that parents/guardians agree that most details of what their child or adolescent tells the therapist be kept confidential. However, parents/guardians do have the right to general information about progress in treatment. The therapist may also have to share information that indicates the child/adolescent is in danger. This is to acknowledge that I have read, understood, and agreed with the above information.

Signature of Client/Parent/Guardian _____ Date _____

This acknowledges that I have reviewed and answered questions about the client's rights and confidentiality as well as our services.

Counselor _____ Date _____