Consent to Use and Disclose Your Health Information

This form is an agreement between you, and me. When I use the words "you" and "your" below, this can mean you, your child, a relative, or some other person if you have written his or her name here: _____

When I examine, test, diagnose, treat, or refer you, I will be collecting what the law calls "protected health information" (PHI). PHI is information that identifies you as a receiver of metal health services and specifies the services that were received including the payment that was provided for the services.

I may need to use this information in my office to decide on what treatment is best for you and to provide treatment to you. I may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are agreeing to let me use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard the notice of privacy practices, which explains in more detail what your rights are and how I can use and share your information. In case no insurance is billed for the services provided or if you, the client, are billing your insurance independently no PHI will be shared outside of the clinic.

If you do not sign this form agreeing to our privacy practices, I cannot treat you. In the future, I may change how I use and share your information, and so I may change our notice of privacy practices. If I do change it while you are in treatment with me, you will be notified.

If you are concerned about your PHI, you have the right to ask me not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although I will try to respect your wishes, I am not required to accept these limitations. However, if we do agree, I promise to do as you asked. After you have signed this consent, you have the right to revoke it in writing.

_____ _____

Signature of client or his or her personal representative Date

_____ _____

Printed name of client or personal representative Relationship to the client

_____

Description of personal representative's authority

_____

Signature of the therapist

Date of NPP: _____ ❑ Copy given to the client/parent/personal representative