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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) about you. I 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 also 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 been exposed to my privacy practices, which explains in more detail what your rights are and how I can use and share your information.

If you do not sign this form agreeing to my privacy practices, I am not allowed to treat you. In the future, I may change how I use and share your information, and so I may change my notice of privacy practices. If I do change it, I will inform you and you can get a copy from me.

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 me what you want in writing. Although I will try to respect your wishes, I am not required to accept these limitations. However, if I do agree, I promise to do as you asked. After you have signed this consent, you have the right to revoke it in writing. I will then stop using or sharing your PHI, but I may already have used or shared some of it, and I cannot change that.

_____ _____

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 authorized representative of this office or practice

Date of NPP: July 16, 2013 ❑ Copy given to the client/parent/personal representative