CONSENT TO THE USE OF DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

Name_____

Birth Date_____

I understand that as part of my healthcare my therapist originates and maintains protected health information (PHI) including health records describing my health history, symptoms, examination & test results, diagnoses, treatment and any plans for future care or treatment.

I hereby give my consent for my therapist to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). *(The Notice of Privacy Practices provided by your therapist describes such uses and disclosures more completely)*

I have the right to review the *Notice of Privacy Practices* prior to signing this consent. Your therapist reserves the right to revise the Notice of Privacy Practices at any time. A revised *Notice of Privacy Practices* may be obtained by forwarding a written request to your therapist.

With this consent, my therapist may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist my therapist in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results, among others.

With this consent, my therapist may mail to my home or other alternative location any items that assist her in carrying out the TPO, such as appointment reminder cards and patient statements.

With this consent, my therapist may email my home or other alternative location any items that assist the therapist in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that my therapist restrict how she uses or discloses my PHI to carry out TPO. My therapist is not required to agree to my requested restrictions, but if she does, it is bound by this consent.

By signing this form, I am consenting to allow my therapist to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the consent that my therapist has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, my therapist may decline to provide treatment to me.

_____I request the following restrictions to the use of disclosure of my health information.

_____
_____
_____

Patient:

_____ _____ _____

Signature of Patient or Legal Representative Date Witness