**Consent for Use or Disclosure of Health Information**

I am very concerned with protecting your privacy. While the law requires me to give you this disclosure, please understand that I have, and always will, respect the privacy of your health information.

There are several circumstances in which I may have to use or disclose your health care information:

* Disclosure to another health care provider, or to a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
* Disclosure to a third party if they are responsible for the payment of your services.
* Disclosure for quality control or other operational purposes.

You have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (§164.520). I reserve the right to change my privacy practices as described in that notice. If I make a change to my privacy practices, I will notify you in writing when you come in for treatment or by mail. Please feel free to call me at any time for a copy of my privacy notice.

**Your right to limit uses or disclosures**

You have the right to request that I do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let me know in writing. I am not required to agree to your restrictions, however, if I do agree, the restriction is binding.

**Your right to revoke your authorization**

You may revoke your consent to me at any time; however, your revocation must be in writing. I will not be able to honor your revocation request if I have already released your health information before I receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read the consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

Date of Expiration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_

Client’s Full Legal Name: (Please print)

Client’s Signature:

Signature of Parent/Guardian if client is under 18:

Parent’s/Guardian’s Name:

Relationship to client: