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CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS (TPO)

Federal regulations (HIPAA) allow me to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for the services I provide, and for other professional activities (known as "health care operations"). Nevertheless, I ask your consent hi order to make this permission explicit. The Notice of Privacy Practices describes these disclosures hi more detail. You have the right to review the Notice of Privacy Practices before signing this consent. I reserve the right to revise the Notice of Privacy Practices at any time. If I do so, the revised Notice will be posted in the office. You may ask for a printed copy of the Notice at any time.

You may ask me to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or health care operations; however, I do not have to agree to these restrictions. If I do agree to a restriction, that agreement is binding.

You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation.

This consent is voluntary. You may refuse to sign it. However, I am permitted to refuse to provide health care services if this consent is not granted or if the consent is later revoked.

I hereby consent to the use or disclosure of my Protected Health Information as specified above.

Signature of Client Date Name of Client

I ACKNOWLEDGE THAT THE HIPAA NOTICE OF PRIVACY PRACTICES IS POSTED DM THIS OFFICE AND THAT A COPY WILL BE MADE AVAILABLE FOR MY PERSONAL USE SHOULD I SO REQUEST.

Signature of Client