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Consent to Use and Disclose your Health Information

This form is an agreement between you, _____ and me, Dyer P. Bilgrave, PhD. When we use the word “you” below, it can mean you, your child, a relative, or other person, if you have written his or her name here _____ .

When I provide you with therapy, examine, test, diagnose, or refer, I will be collecting what the law calls “protected healthcare information (PHI) about you. I need to use this information to decide what treatment is best for you and to provide that 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. When you sign this form, your signature acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

If you do not sign this consent form, I cannot treat you.

In the future, I may change how I use and share your information and so may change my notice of privacy practices. If I do change it, you can get a copy from my website or by asking me.

If you are concerned about some of your PHI, you have the right to ask me not to use or share it for treatment, payment, or administrative purposes. You will need to tell me what you want in writing. Although I will try to respect your wishes, I am not required to agree to 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 by writing me a letter telling me that you no longer consent. 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 is 3/15/2010

Copy given to the client/parent/personal representative.