Healthy Minds Counseling LLC

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Consent to Use and Disclose Your Health Information

This form is an agreement between you, and me/us, When we 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 we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls “protected health information” (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We 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 us use your PHI and to send it to others for the purposes described above.

Your signature below acknowledges that you have read and received our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

_____ _____

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: _____

❑ Copy of Notice of Privacy Practices given to the client/parent/personal representative