CONSENT TO COMPLY WITH FEDERAL HIPAA ACT Patient Consent for Use and Disclosure of Protected Health Information With my consent and signature, Rainier Speech Therapy, LLC may use and disclose protected health information about me or my child to:

1. Carry out treatment, payment and healthcare operations (services).
2. Call my home or other designated locations and leave a message on voice mail in reference to any items (i.e. appointment reminders, insurance items, references to clinical care of laboratory results, etc.) that will assist in the practice of medical care for me or my child.
3. Mail to my home or other designated address any item (i.e. appointment reminder cards, patient financial statements, etc.) that will assist in practice of medical care for me or my child. Such correspondence is to be marked personal or confidential.
4. Send or transmit email to any location provided by me for all above similar items and purposes.
5. To use and/or disclose protected health information about me or my child to/with third parties involved in mine or my child's care. Such parties may include, but are not limited to, insurance companies, hospitals, specialty physicians and laboratory personnel. I may specifically describe the type of information (i.e. dates of services, level of detail, origin of information, etc.) subject to disclosure and may revoke this permission at a time and date chosen by me. By providing a written statement to the privacy office of Rainier Speech Therapy, LLC, I may revoke this permission; however, Rainier Speech Therapy, LLC may decline to provide further treatment to me or my child. Rainier Speech Therapy, LLC may also decline further treatment to me or my child should my restrictions on the type of third party information, in the our office's opinion, impede medical care of me or my child. I have the right to review the Notice of Privacy Practice Manual of Rainier Speech Therapy, LLC.

Rainier Speech Therapy, LLC may revise its manual and procedures at any time deemed necessary, and I may request from time to time, in writing, a copy of such changes, should these changes directly relate to mine or my child's care. I have the right to request that Rainier Speech Therapy, LLC restrict how it uses or discloses mine or my child's health information. However, as stated previously, Rainier Speech Therapy, LLC is not required to agree to my restrictions. If Rainier Speech Therapy, LLC accepts my restrictions, The Rainier Speech Therapy, LLC is then bound by the restriction in the agreement, setting forth the restricted information until providing me, in writing, a cessation of such agreement. I may revoke this entire consent, in writing, at any time. If I do not sign this consent or revoke this consent, Rainier Speech Therapy, LLC, in their sole discretion, may decline further treatment for me or my child. The HIPAA Privacy Act of 2001 was created to protect mine and my child's

health information. I understand this must be accomplished within the provisions and rules set up by Rainier Speech Therapy, LLC to fulfill federal law. I may request to review the manual which spells out these provisions. Rainier Speech Therapy, LLC will comply with this law to preserve privacy. If compliance with this law impedes the medical care of the patient, Rainier Speech Therapy, LLC may decline to provide further care. Rainier Speech Therapy, LLC will strive to provide information so that I may make an informed decision concerning the privacy of mine or my child's medical information.

_____

Patient Printed Name

_____ _____

Patient Signature Date

_____ _____ _____

Signature of Consenting Party Relationship to Patient Date