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CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This form is an agreement between you, _____ and me, Rosa C. Gonzalez, M.D. When we use the word "you" below, it will mean your child, relative, or other person if you have written his or her name here _____.

When I examine, diagnose, treat, or refer you. I will be collecting what the law calls Protected Health Information (PHI) about you. I need to use this information here to decide on what treatment is best for you and to provide treatment to you. I may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form, you are agreeing to let me use your information here and send to others. This Notice of Privacy Practices explains in more detail your rights and how I can use and share your information. Please read this before you sign this Consent form.

Please Note: If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices, I cannot treat you.

In the future I may change how I use and share your information and so may change our Notice of Privacy Practices. If I do change it, you can get a copy by calling me at (409)892-9347 during office hours.

If you are concerned about some of your information, you have the right to ask me to not use or share some of your information for treatment, payment or administrative purposes. You will have 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 comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling me that you no longer consent) and I will comply with your wishes about using or sharing your information from that time on but I may already have used or shared some information and cannot change that.

_____ _____
Signature of client / or parent or guardian Date

_____
Printed Name of client / or parent or guardian

_____ _____ _____
Relationship to client Witness Date

Date of NPP _____ Copy given to the Client / Parent / or Guardian ____