



## Consent to Use and Disclose Your Health Information

**Please read the NPP (Notice of Privacy Practices) before you sign this Consent form. The form must be signed before we can treat you.**

When we examine, 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 to decide what type of treatment is best for you and to provide that treatment to you. We 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.

In the future we may change how we use and share your information. We may change our Notice of Privacy Practices. If we do change it, you can obtain a copy from the office or the privacy officer.

If you are concerned about any of your information, you have the right to ask us not to use or share that specific information for treatment, payment or administration purposes. You will have to tell us what you want in writing. Although we will read what you have requested, we are not required to agree to the limitations. However, if we agree, we will comply with your wishes.

After you have signed this consent, you have the right to revoke it, by informing us, in writing, and from that time forward we will comply, however prior to that request we may have already used or shared some of your information and cannot change that.

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Name (please print)

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Signature of client or personal representative

Date

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Printed name of personal representative

Relationship to client

\_\_\_ no, I do not want a copy of this Consent

\_\_\_ copy requested and given