Ron Latsha, MS,LPC

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: CLIENT GIVING CONSENT

Name of client: ____

Name of parent or guardian (if client is a minor):______________________________________

SECTION B: Important Information - PLEASE READ THE FOLLOWING STATEMENTS CARE FULLY

Purpose of Consent: By signing this form, you will be giving your consent to my use and disclosure of your protected health care information. This information will be utilized solely for the rendering of mental health treatment and associated payment activities.

Notice of Privacy Practices: You have the right to read my Notice of Privacy Practices before deciding whether to sign this Consent. My Notice provides a description of the uses and disclosures I may make of your protected health information and of other important matters about your protected health information. A copy of my Notice of Privacy Practices is displayed in the office for your convenience. I encourage you to read it carefully before signing this Consent.

As circumstances may dictate, and within the limits of the law, I reserve the right to change my Privacy Practices. If changes are implemented, they will be posted for your review. Said changes may apply to your Health Care Information which was previously obtained.

You may obtain a copy of my Notice of Privacy Practices, including any revisions of my Notice, at any time by contacting me.

Right to Revoke: You have the right to revoke this Consent at any time by giving me written notice of revocation submitted to the above address. Please understand that revocation of this Consent will not affect any action I took in reliance on this Consent before I received your revocation.

I,____, have had full opportunity to read and consider the contents of this Consent form and this office's Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to the use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:____Date: ________________

If this Consent is signed by a parent/guardian/personal representative on behalf of the client, complete the following:

Printed Name:____

Relationship to Client:____

Please sign and date: The "**Notice of Privacy**" is posted in the waiting room. Please read it at your own discretion.

I,____ acknowledge that on _______________________________
Date

have, on behalf of myself and/or any minor or incapacitated dependents, read and understand this office's Notice of Privacy Practices.

Signature:____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT