Consent for Uses and Disclosures to Carry Out Treatment, Payment, and Health Care Operations

Patient Name: _____

Federal regulations (HIPAA) allow health service providers to disclose Protected Health Information (PHI) from your records in order to provide you treatment services, obtain payment for the services provided, or for other professional activities known as “health care operations”.

I ask your consent in order to make this permission clear, with the Notice of Privacy Practices specifically describing these disclosures. You have the right to review the Notice of Privacy Practices before signing this consent. I reserve the right to revise our Notice of Privacy Practices at any time. If a revision has been made, the revised Notice of Privacy Practices will be posted in the office, and you may request at any time a printed copy of the revised Notice of Privacy Practices.

You may ask me to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for your treatment, payment, or health care operations; however, I do not have to agree to these restrictions. If we do agree to a restriction, that agreement is binding.

You may revoke this consent at any time by submitting a written request for revocation of Consent for Uses and Disclosures to Carry Out Treatment, Payment and Health Care Operations, to Virginia L. Watford, Ph.D. at 27405 Puerta Real, Suite 150, Mission Viejo, CA. 92691. Such revocation will not affect any action taken in reliance on the consent prior to the revocation.

This consent is voluntary and you may refuse to sign it. However, I am permitted to refuse to provide health care services if this consent is not granted, or terminate health care services and refer you to another service provider if the consent is later revoked.

I hereby consent to the use or disclosure of my Protected Health Information as specified in this document.

Signature of Patient: _____ Date: _____