CONSENT

TO THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, HEALTHCARE OPERATIONS, AND AS OTHERWISE ALLOWED BY LAW

Child Neuropsychology & Counseling Center will maintain a record of the mental health care and services you receive in our office. This consent only covers your protected health information (PHI) created while you are a patient of Child Neuropsychology & Counseling Center. Your protected health information (PHI) pertains to your diagnosis and/or treatment at Child Neuropsychology & Counseling Center, including but not limited to, information concerning mental illness (except for psychotherapy notes), use of alcohol or drugs or communicable diseases such as HIV, and AIDS, lab test results, medical history, treatment progress or any other such related information.

By signing this form, you consent to Child Neuropsychology & Counseling Center's use and/or disclosure of protected health information (PHI) about you for treatment, payment, and healthcare operations and as otherwise allowed by law. Our *Notice of Privacy Practices* provides information about how Child Neuropsychology & Counseling Center and its clinicians may use and disclose protected health information (PHI) about you for treatment, payment and healthcare operations and as otherwise allowed by law.

By signing this form, you also acknowledge that you have received a copy of the *Notice of Privacy Practices* and an opportunity to review it before signing this consent.

_____ _____

Name of Patient Patient's DOB

_____ _____

Signature of Patient/Legal Representative Date

_____

Witness