Psychological Associates
of Schuylkill County LLC

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CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Your protected health information will be used by this practice, known as, PSYCHOLOGICAL ASSOCIATES OF SCHUYLKILL COUNTY, LLC or disclosed to others for the purposes of treatment, obtaining payment or supporting the day-to-day health care operations of the practice.

We are providing you with a copy of our Notice and Privacy Practices. We request that you review the notice prior to signing this consent. You may request a restriction on the use or disclosure of your protected health information. If you should wish to restrict your disclosure, you should make the request in writing. This practice, however, may or may not agree to restrict the disclosure of your protected health information. If we agree to your request, the restriction will be binding. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of federal privacy standards.

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date of your revocation of consent is received will not be affected. This practice reserves the right to modify the privacy practices outlined in the notice.

I have reviewed this consent form and have reviewed the Notice of Privacy Practices. I give my permission to this practice to use and disclose my health information in accordance with this form. I acknowledge consent and agree to the terms and conditions of this document.

Name of Patient (print clearly)_____

Signature of Patient _____

Signature of Patient Representative _____

Relationship of Representative to Patient _____ Date _____