

## Notice of HIPAA Regulations and Consent Form

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we will honor that agreement. Upon request, a Notice of Privacy Practices will be provided.

By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior consent. This office provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPA).

The client understands:

Protected health information may be disclosed or used in treatment, payment, or health care operations  
Client has an opportunity to review Notice of Privacy Practices  
Client has the right restrict the uses of their information but that this office does not have to agree to those restrictions  
Client may revoke this consent in writing at any time and all future disclosures will cease  
This office may condition receipt of treatment upon execution of this consent

Client name \_\_\_\_\_ Therapist \_\_\_\_\_

Signature \_\_\_\_\_ Signature \_\_\_\_\_

Date \_\_\_\_\_

Relationship to Client (if other than client) \_\_\_\_\_