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## Consent to Use and Disclose Your Health Information

This form is an agreement between you, and Medical Psychology Services, When we use the words “you” and “your” below, this can mean you, your child, a relative, or some other person if you have written his or her name here.

When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls “protected health information” (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, or to help provide other treatment to you. By signing this form, you are agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains what your rights are and how we can use and share your information.

If you do not sign this form agreeing to our privacy practices, we cannot treat you.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked. After you have signed this consent, you have the right to revoke it by writing. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

\_\_\_\_\_  
Signature of client or his or her personal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of client or personal representative

\_\_\_\_\_  
Relationship to the client

\_\_\_\_\_  
Signature of authorized representative of this office or practice