

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Social Security Number or Driver's License Number: _____

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you consent to our use and disclosure of your protected health information. Your personal information will not be used or distributed for marketing purposes or activities that may breach professional confidentiality standards. This form is designed to comply with Federal Law, which requires this office to supply you with this consent form.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our notice provides a description of our treatment, payment activities, and other operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by requesting one.

Right to Revoke: You will have the right to revoke this consent at any time by giving written notice of your revocation submitted to the contact person listed below. Please understand that revocation of this consent will *not* affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

CONTACT PERSON: Jim Harris, 1900 East Tahquitz Canyon Way, Suite C-4, Palm Springs CA 92262

I, _____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment and payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Name: _____

Relationship to Client: _____

You are entitled to a copy of this consent after your sign it. Please ask for a copy if you would like one.