

## Consent To Use and Disclose Your Health Information

This form is an agreement between you, \_\_\_\_\_ and myself, Judy Dearing, LCSW.

Child's name if your child is the client: \_\_\_\_\_.

When I assess, diagnose, treat, or refer you I will be collecting what the law calls Protected Health Information (PHI) about you. I need to use this information here to decide on what treatment is best for you and to provide treatment to you. I may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or governmental functions.

By signing this form you are agreeing to let me use your information here and send it to others. The Notice of Privacy Practices explains in more detail your rights and how I can use and share your information. Please read this before you sign this Consent Form. In the future I may change how I use and share your information and so may change my Notice of Privacy Practices. If I do change it, you can get a copy by calling me at (828) 696-2222 or from me at my office.

If you are concerned about some of your information, you have the right to ask me to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to agree to these limitations. However, if I do agree, I promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling me you no longer consent) and I will comply with your wishes about using or sharing your information from that time on but I may already have used or shared some of your information and cannot change that.

Signature of client: \_\_\_\_\_ Date: \_\_\_\_\_

Printed name of client: \_\_\_\_\_ Date of NPP \_\_\_\_\_ Copy given to client \_\_\_\_\_

## Receipt and Acknowledgment of Notice of Privacy Practices

I have received and been given an opportunity to read a copy of the short version of "Notice of Privacy Practices." I understand this information and upon my request to Ms. Dearing, may receive a copy of the full document. I understand that I may address any concerns or grievances with my therapist, Judy Dearing, LCSW, the representative of my insurance company, or the Secretary of the Department of Health and Human Services. I also understand that I may contact the licensing board which regulates my therapist's professional practice if I have any concerns about my treatment which I have shared with my therapist but have not been addressed by her.

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*Signature of Client*

*Date*

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*Signature of Parent, Guardian, or Personal Representative\**

*Date*

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*\* Describe your legal authority to act for this individual (power of attorney, etc.)*

\_\_\_ Client Refuses to Acknowledge Receipt:

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*Judy Dearing, LCSW*

*Date*