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Consent to Use and Disclose Your Health Information

This form is an agreement between you, _____, and me, Amie Kuykendall, LCSW. When I use the words "you" and "your" below, this can mean you, your child, or a person for whom you are the legal or personal representative if you have written his or her name here: _____.

When I examine, evaluate, 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 in our office to decide what treatment is best for you and to provide this treatment to you. I may also share this information with others to arrange payment for your treatment, to help others provide other treatment to you, or to carry out certain business or government functions.

By signing this form, you are agreeing to let me use your PHI here and to send it to others for the purposes described just above. Your signature below acknowledges that you have read or heard the Notice of Privacy Practices, which explains in more detail what your rights are and how I can use and share your information. If you do not sign this form agreeing to our privacy practices, I cannot treat you, because I need to use your PHI to evaluate, diagnose, and treat you.

In the future, I may change how I use and share your PHI, and so I may change my Notice of Privacy Practices. If I do change it, you can get a copy from my website www.aektherapy.com, or you may request a copy from my office.

After you have signed this consent, you have the right to revoke it with a written request. I will then stop using or sharing your PHI, but if I have already used or shared some of it, I cannot change that.

_____ ___/___/___

Signature of client or personal representative Date

_____ _____

Printed name of legal representative Relationship to client

_____

Description of personal representative's authority

_____

Signature of authorized representative of this office or practice

❑ Copy given to the client/parent/personal representative 02/04/2018