DAVIS PSYCHOLOGICAL SERVICES CONSULTING, PLLC

CONSENT TO USE OR DISCLOSE INFORMATION FOR TPO

Patient Name_____

Federal regulations (HIPAA) allow me to use or disclose PHI from your record in order to provide treatment to you, to obtain payment for the services we provide, and for other professional activities (known as "health care operations"). Nevertheless, I ask your consent in order to make this permission explicit. The notice of privacy practices describes these disclosures in more detail. You have the right to review the notice of privacy practices before signing this consent. We reserve the right to revise our notice of privacy practices at any time. If we do so, the revised Notice will be posted in the office. You may ask for a printed copy of our notice at any time.

You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or health care operations; however, we do not have to agree to these restrictions. If we do agree to a restriction, that agreement is binding.

You may revoke thus consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation.

This consent is voluntary; you may refuse to sign it. However, we are permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked.

I hereby consent to the use or disclosure of my PHI as specified above.

I authorize payment of medical benefits directly to the physician or supplier of services.

Signature of Patient:_____ Date:_____