

Washington Psychological Services
87 East Maiden Street, Suite 2, Washington, PA 15301
Phone: (724)222.8525 Fax: (724)222.8545

Consent to Use and Disclose Your Health Information

This form is an agreement between you, and me/us. 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, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purpose described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail 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. In the future, we may change how we use and share your information, and so we may change our privacy practices. If we do change it, you can get a copy by calling us at (724)222-8525 or from Michael Crabtree, Ph.D., Licensed Psychologist, our privacy officer.

If you are concerned about you 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 to our privacy officer. We will then stop using or sharing your PHI, but we 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

Description of personal representative’s authority

Signature of authorized representative of this office or practice

Date of NNP: _____

Copy given to the client/parent/personal representative