PSYCHSERVES

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NOTICE OF HIPAA REGULATIONS

You have the right to request restrictions on how protected health information about you is used or disclosed for treatment, payment, or health care operation. Our office is not required to agree to this restriction, but will honor said restrictions on agreement. Upon request, a Notice of Privacy Practices will be provided.

By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment, and health care operations. You have the right to revoke this consent, in writing, with your signature. However, revoking consent shall not affect any other disclosures we have already made on your prior consent. Our office provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The client understands:

1. Protected health information may be disclosed or used in treatment, payment, or health care operations.
2. The client has the opportunity to review a Notice of Privacy Practices.
3. The client has the right to restrict the use of their information but our office is not required to agree to those restrictions.
4. The client may revoke this consent, in writing, at any time so that all future disclosures will cease.
5. Our office may conditionally give treatment upon execution of this consent.

Client name: _____

Signature: _____ Date: _____

Relationship to Client (if other than client): _____