Kate McNulty LCSW

Consent to Use and Disclose Your Health Information

This form is an agreement between you, _____ and me, Kate McNulty LCSW. When we use the word "you" below, it can mean you, your child, a relative, or other person if you have written his or her name here _____ .

When I examine, diagnose, treat, or refer you I will be collecting what the law calls Protected Healthcare Information (PHI) about you. I may need to use this information to decide on what treatment is best for you and to provide any 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 government functions. By signing this form you are agreeing to let me use your information and send it to others. However, I will never contact anyone about your treatment without your written permission. The Notice of Privacy Practices explains in more detail your rights and how I can use and share your information. Please read this document if you wish, before you sign this Consent.

The transmission and sharing of health information has become a complex subject. Please let me know of any concerns and questions you have about your privacy so we can discuss them. 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 by notifying me exactly what you want in writing. Although I will try to accommodate any request, the law does not require me to agree to the limitations you specify. In the future I may change how I use and share your information and so may change my Notice of Privacy Practices. If so, I will update you in writing.

After you have signed this consent, you have the right to revoke it (by writing a letter to my Privacy Officer, ie me, 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 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 NPP _____ _____Copy given to the client/parent/personal representative