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Consent to Use and Disclose Your Protected Health Information (PHI)

This form is an agreement between you, and me, 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 I examine, test, 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 my office to decide on what treatment is best for you and to provide treatment to you. I 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 me use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard my notice of privacy practices, which explains in more detail what your rights are and how I use and share your information.
In the future, I may change how I use and share your information, and so I may change my notice of privacy practices. If I do change it, you can get a copy by calling me at (323)-645-0824.

If you are concerned about your PHI, you have the right to ask me not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to accept these limitations. However, if I do agree, I promise to do as you asked. After you have signed this consent, you have the right to revoke it in writing. I will then stop using or sharing your PHI, but I may already have used or shared some of it, and I cannot change that.

_____ _____
Signature of client or his or her personal representative Date

_____
Printed name of client or personal representative

_____
Relationship to 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