New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I _____ understand that as part of my health care, Molly Larson, Ph.D., Licensed Clinical Psychologist, originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment;
- A means of communicating among the health professionals who contribute to my care;
- A source of information for applying my diagnosis and information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been offered a copy of Notice of Privacy Practices, which provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent;
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations.

I understand that Molly Larson, Ph.D., Licensed Clinical Psychologist, is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that action has already been taken in reliance thereon. I also understand that by refusing to sign or revoking this consent Molly Larson, Ph.D., Licensed Clinical Psychologist, my refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.
I further understand that Molly Larson, Ph.D., Licensed Clinical Psychologist, reserves the right to change the notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations, she will send a copy of any revised notice to the address I have provided, upon my written request.
I wish to have the following restrictions to the use of disclosure of my health information:

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I understand that as part of Molly Larson, Ph.D., Licensed Clinical Psychologist treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via FAX.

I fully understand and accept / decline the terms of this consent.

_____ Date_____
Client's Signature (Legal guardian, if client is a minor)

FOR OFFICE USE ONLY
( ) Consent received by _____ Date_____
( ) Consent refused by patient, and treatment refused as permitted.