HIDDEN SPRINGS PSYCHOLOGICAL SERVICES

Consent for Purposes of Treatment, Payment and Mental Health Care Operations

I consent to the use or disclosure of my protected health information by **Hidden Springs Psychological Services** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct mental health care operations of **Hidden Springs Psychological Services**. I understand that diagnosis or treatment of me by **Dr. _____, Psychologist** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or mental health care operations of the practice. **Hidden Springs Psychological Services** is not required to agree to the restrictions that I may request. However, if **Hidden Springs Psychological Services** agrees to a restriction that I request, the restriction is binding on **Hidden Springs Psychological Services** and **Dr. _____, Psychologist**.

I have the right to revoke this consent, in writing, at any time, except to the extent that **Dr. _____, Psychologist** or **Hidden Springs Psychological Services** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my mental health provider, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **Hidden Springs Psychological Services'** Notice of Privacy Practices prior to signing this document. The **Hidden Springs Psychological Services'** Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of **Hidden Springs Psychological Services**. The Notice of Privacy Practices for **Hidden Springs Psychological Services** is also provided **in the waiting room where NPP are available** and on the **Hidden Springs Psychological Services**' website at **www.hiddensprings.info.** This Notice of Privacy Practices also describes my rights and the **Hidden Springs Psychological Services'** duties with respect to my protected health information.

Hidden Springs Psychological Services reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the **Hidden Springs Psychological Services'** website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Client or Personal Representative Date

_____

Print Name of Client or Personal Representative

_____

Description of Personal Representative's Authority