Rachael Patoray, LPC, ATR
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CONSENT TO USE OR DISCLOSE CLINICAL INFORMATION:

I Authorize Rachael Patoray, LPC, ATR to use and disclose the health and clinical information of _____ (please print client name) for the purpose of Treatment*, Payment** and health Care Operations***

*** Treatment** includes activities performed by myself in providing care to you, coordinating or managing your care with third parties and consolations with an between other health care professionals. This consent includes treatment provided by any professional who covers for me and an on-call professional.

**** Payment** includes uses and disclosures required for determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims and health plan management activities which may include review of your services for clinical necessity, justification of charges, pre certification and preauthorization.

***** Health Care Operations** includes the administrative and business functions of this practice.

You should review my Notice of Practices for additional information about the uses and disclosures of information described in this CONSENT prior to signing this CONSENT.

Because I reserve the right to change my privacy practices in accordance with the HIPAA Privacy rules, the terms contained in the ***Notice of Privacy Practices*** may change also. A summary of the ***Notice of Privacy Practices*** will be posted in the waiting room indicating the effective date of my current ***Notice of Privacy Practices*** in the upper right hand corner. I will offer you a copy of the ***Notice of Privacy Practices*** on your first visit after the effective date of the current Notice of ***Privacy Practices***. You will be given a copy of the ***Notice of Privacy Practices*** at your request.

As more fully explained in the ***Notice of Privacy Practices***, you may have the right to request restrictions on how I use and disclose your protected health information for treatment, payment and health care operations. I am not required to agree to your request. If I agree, I am required to comply with your request unless the information is needed to provide emergency treatment to you. Other practitioners who provide coverage for my practice are required to use and disclose your protected health information consistent with the ***Notice of Privacy Practices.***

Client/Guardian Signature:_____ Date:_____

Contact Information for Consent to Use or Disclose Clinical Information
Please include Below: Name, Relationship to Client, Address, Phone, Fax#: