CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I hereby acknowledge receipt of a written notice of my privacy rights and I consent to **TherapyWorks** using and disclosing my protected health information to carry out treatment, payment or healthcare operations.

I understand and have been provided with a Notice of Privacy Practice, which provides a more complete description of how my protected health information may be used or disclosed. I understand that I have the right to review the notice prior to signing this consent.

I understand that **TherapyWorks** reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by written request. Address to **TherapyWorks**, 500 Quintana Rd., Morro Bay, CA 93442

I understand that I have the right to restrict how **TherapyWorks** uses or discloses my protected health information to carry out treatment, payment of health care operations; and that TherapyWorks is not required to agree to the restrictions and; that **TherapyWorks** is bound by restrictions to which it agrees.

I request the following restrictions/permissions as to how, or to who my health information is used or disclosed:

Please allow_____, Relation to you_____ to

__Know my Schedule __ Change my schedule __Discuss my healthcare __Discuss my billing

Other comments:

_____

_____

_____

I have the right to revoke this consent by notifying TherapyWorks in writing, except to the extent that TherapyWorks has taken action in reliance of my consent.

_____ _____

Signature of patient or representative Date

_____ _____

Printed name of patient or representative Relationship to patient

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