Lewisville Family Counseling PLLC

Consent to Use and Disclose Your Health Information

This form is an agreement between you, _____and Lewisville Family Counseling, PLLC. 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 we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We 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 us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

If you do not sign this form agreeing to our privacy practices, we cannot treat you. In the future, we may change how we use and share your information, and so we may change our notice of privacy practices. If we do change it, you can get a copy from our website, www.lewisvillefamilycounseling.com, or by calling us at 336-945-0137.

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

_____ _____

Signature of client or his or her personal representative Date

_____ _____

Printed name of client or personal representative Relationship to the client

_____

Description of personal representative's authority

_____

Kervins Clement, LCMHCA, LCASA, NCC, CRT-IT, CFLE, M.Ed., Ed.S

Date of NPP: _____

® Copy given to the client/parent/personal representative