PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

With my consent, my therapist, *Anne G. Walker LCSW*, may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to my therapist's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent.

My therapist reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to my therapist's Privacy Officer at 4811 Emerson Ave. Suite 101, Palatine, Il 60067.

With my consent, my therapist and his/her staff, may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as insurance items and any call pertaining to my clinical care.

With my consent, my therapist and/or staff, may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as patient statements as long as they are marked Personal and Confidential.

I have the right to request that my therapist's office restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to my therapist to the use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, my therapist may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Date_____

_____
Patient's Name

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Print Name of Patient or Legal Guardian