

Consent to Use and Consent to Disclose Your Health Information

This form is an agreement between you, _____ and Jonas Horwitz, Ph.D. When we use the word “you” below, it will mean your child, relative, or other person if you have written his or her name here _____.

When we examine, 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 here to decide on what treatment is best for you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let us use your information here and send it to others. The **Notice of Privacy Practices** explains in more detail about your rights and how we can use and share your information. Please read this before you sign this consent form. A copy is attached to this form in our waiting room and is available online at our website, www.Jonashorwitz.com.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy from our website, www.Jonashorwitz.com or by calling us at 919-401-6171.

If you are concerned about some of your information, you have the right to ask us not to use or share some of your information for treatment, payment or administrative purposes. You have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations per the legal limitations of confidentiality which I will review with you in our first session.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us that you no longer consent) and we will comply with your wishes about using and sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

Signature of client or his or her representative

Date

Printed name of client or representative

Relationship to the client

Description of personal representative's authority

Date NPP copy given to the client/parent/representative