

Consent to Use PHI for Treatment, Payment, and Healthcare Operations

With my consent, Westchester LCSW Counseling Services, PLLC may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Westchester LCSW Counseling Services, PLLC, 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. Westchester LCSW Counseling Services, PLLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Westchester LCSW Counseling Services, PLLC.

With my consent, Westchester LCSW Counseling Services, PLLC may call my cell phone or 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 appointment reminders, insurance items, and any call pertaining to my clinical care.

With my consent, Westchester LCSW Counseling Services, PLLC may mail to my home or other designated location any items that assist in carrying out TPO, such as appointment reminder cards and patient statements, as long as they are marked Personal and Confidential.

With my consent, Westchester LCSW Counseling Services, PLLC may email to me my appointment reminder cards and patient statements. I have the right to request that Westchester LCSW Counseling Services, PLLC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is required by state statutes to agree to my requested restrictions, unless in extenuating circumstances allowed by law.

By signing this form, I consent for Westchester LCSW Counseling Services, PLLC to use and disclose 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, Westchester LCSW Counseling Services, PLLC may decline to provide treatment to me.

Signature of Client or Legal Guardian

Date

Print Name of Client or Legal Guardian
