LSW
Psychological Services
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Patient Consent for Use and Disclosure
of Protected Health Information (HIPPA Acknowledgement)

I hereby give my consent for LSW Psychological Services to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by LSW Psychological Services describes such uses and disclosures more completely.)

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

LSW Psychological Services 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 Dr. LeighAnn Wong (239) 599-5656.

With this consent, LSW Psychological Services may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including test results, among others.

With this consent, LSW Psychological Services may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked “Personal and Confidential.”

With this consent, LSW Psychological Services may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that LSW Psychological Services restrict how it uses or discloses my PHI to carry out TPO. 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 allow LSW Psychological Services 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, or later revoke it, LSW Psychological Services may decline to provide treatment to me.

_____ _____

Name of client Date

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Signature of adult client or parent/guardian of client