Behavioral Health Associates

Consent to Use and Disclose Your Health Information

This form is an agreement between you, _____, and Behavioral Health Associates. 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 to decide what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you, who 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 and send your information to others. The Notice of Privacy Practices (NPP) explains in more detail your rights and how we can use and share your information. Please read the NPP before you sign this consent form.

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 may therefore change our Notice of Privacy Practices. If we do change it, you can get a copy in our office or from our Privacy Officer.

You have the right to ask us not to use or share some of your information 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 agree to these limitations; however, if we do agree, we promise to comply with your wish.

After you have signed this consent form, you have the right to revoke it by writing a letter telling us you no longer consent. We will comply with your wishes about using or sharing your information from that time on, although we cannot change the fact that some information may have been sent or shared before that date.

_____	_____	_____
Signature of Patient	Printed Name of Patient	Date
_____	_____	_____
Signature of Personal Representative	Printed Name of Personal Representative	Date

_____ _____

Description of Personal Representative's Authority | Relationship to the Patient

❑ NPP copy given to the patient/parent/personal representative.

Date _____