

CARL L. POTTER, III LCSW

Consent to Use And Disclose Your Health Information

This form is an agreement between you, _____, and I, Carl Potter, LCSW, and includes any dependents, relatives, or other person included below.

When I treat, refer, test, or diagnose you, I will be collecting what the law calls *protected healthcare information (PHI)*. I will use that information for treatment formulation and treatment planning. I may also share this information with others who provide treatment for you or those persons who are involved with insurance reimbursement, business, and government functions.

By signing this form, you are agreeing to let me use your PHI for the above mentioned purposes. The Notice of Privacy Practices (NPP) explains in more detail your rights and how we can use and share your information. Please read it before you sign this form.

IF YOU DO NOT SIGN THIS CONSENT FORM AGREEING TO WHAT IS IN MY NOTICE OF PRIVACY PRACTICES I CANNOT TREAT YOU.

In the future, I may change how I use and share your information. Which would mean a change in the NPP. If I do change it, you can get the new version from my website: cp3psych.com.

If you are concerned about some of your PHI, you have the right to refuse disclosure for treatment, payment, or administrative purposes. You must present this request in writing. As explained in the NPP, I am not required to agree to these limitations but I will do my best to comply with your privacy wishes. At any time, after you have signed this consent, you may revoke your consent for disclosure. This must also be submitted in writing.

Signature of client or personal representative

Printed name