Karen A. DeKleva M.A.

Karen A. DeKleva
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Adult Therapy

Consent to use and disclose your health information

This form is an agreement between you,_____and me, Karen DeKleva, Psychologist.

I am collecting information on you that the law calls Protected Health Information or PHI. I need this information to diagnose, treat, or refer you. I use this information here to decide on what treatment is best for you and to provide treatment to you. I may also share this information with others who provide treatment to you or to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let me use your information here and send it to others. The Notice of Privacy Practices explains in more detail your rights and how I can use and share your information. Please read this before you sign this consent form.

If you do not sign this consent form agreeing to what is my Notice of Privacy Practices I cannot treat you.

In the future I may change how I use and share your information, you have the right to ask me not to use or share some of your information for treatment, payment or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to agree to these limitations. However, if I do agree, I promise to comply with your wish.

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

_____ _____
Signature of client Date

_____
Printed name of client

Date _____ ___ Copy given to the client/parent/personal representative