CONSENT TO USE OR DISCLOSE
CLINICAL INFORMATION

I authorize **K. Brynolf Lyon, Ph.D., LMHC** to use and disclose the health and clinical information of _____ for the purposes of Treatment*, Payment** and Health Care Operations***.

> ***Treatment** (includes activities performed by K. Brynolf Lyon, Ph.D., LMHC providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care professionals. This consent includes treatment provided by any professional who covers this practice as an on-call professional).
>
> ****Payment** (includes uses and disclosures required for determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and health plan management activities which may include review of your services for clinical necessity, justification of charges, pre-certification and pre-authorization).
>
> *****Health Care Operations** (includes the administrative and business functions of this practice).

You should review my ***Notice Of Privacy Practices*** for additional information about the uses and disclosures of information described in this CONSENT prior to signing this CONSENT.

Because we reserve the right to change our privacy practices in accordance with the HIPAA Privacy Rules, the terms contained in the ***Notice of Privacy Practices*** may change also. A summary of the ***Notice of Privacy Practices*** will be posted *in my office* indicating the effective date of our current ***Notice of Privacy Practices*** in the upper right hand corner. We will offer you a copy of the ***Notice of Privacy Practices*** on your first visit to us after the effective date of the current ***Notice of Privacy Practices***. *Y*ou will be given a copy of the ***Notice of Privacy Practices*** at your request.

As more fully explained in the ***Notice of Privacy Practices***, you may have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations. *We are not required to agree to your request.* If we agree, we are required to comply with your request unless the information is needed to provide emergency treatment to you.

Other practitioners who provide coverage for this practice are required to use and disclose your protected health information consistent with the ***Notice of Privacy Practices*** .

Please verify that you have received a copy of our ***Notice of Privacy Practices*** by signing your initials here _____.

I understand that I have the right to revoke this CONSENT provided that I do so in writing, except to the extent that this practice has already used or disclosed the information in reliance on this CONSENT.

Signature of

Client_____Date_____

Signature of Legal Guardian or

Representative_____Date_____

Please indicate the nature of your relationship to the client_____