



Nancy J. Patrick, Ph.D. LLC

**Acknowledge of Receiving Notice of Privacy Practices  
Consent to Use and Disclose Your Health Information**

This form is an agreement between you, \_\_\_\_\_ and me, \_\_\_\_\_ . When I use the words “you” and “your” below, this can mean you, your child, a relative, or some other person if you have written his or her name here: \_\_\_\_\_ .

When I examine, test, diagnose, treat, or refer you, I will be collecting what the law calls “protected health information” (PHI) about you. I need to use this information in my office to decide on what evaluations may be needed along with the best treatment for you and to provide treatment to you. I may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you.

By signing this form, you are also agreeing to let me use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard my notice of privacy practices, which explains in more detail what your rights are and how I can use and share your information.

If you do not sign this form agreeing to my privacy practices, I cannot evaluate or treat you. In the future, I may change how I use and share your information, and so I may change my notice of privacy practices. If I do change it, you will get a copy by directly asking me for it.

If you are concerned about your PHI, you have a right to ask me not to use or share some of it 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 accept these limitations. However, if I do agree, I promise to do as you asked.

After you sign this consent, you have the right to revoke it by writing to me. I will then stop using or sharing your PHI, but I may already have used or share some of it, and I cannot change that.



Nancy J. Patrick, Ph.D. LLC

\_\_\_\_\_  
Signature of client or his/her personal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of the client or personal representative

\_\_\_\_\_  
Relationship to the client

\_\_\_\_\_  
Signature of authorized representative of this practice

\_\_\_\_\_  
Date of NPP

[ ] Copy given to the client/parent/spouse/representative