Kathryn J. Cann, LCSW

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CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This form is an agreement between you, _____
and me/ **Kathryn J. Cann, LCSW.**
use the word "you" below, it can mean you or your child, relative, or other person if you have written their name here: _____.

When I examine, test, diagnose, treat, or refer you I will be collecting what the law calls Protected Healthcare Information (PHI) about you. I need to use this information here to decide on what treatment is best for you and to provide any treatment to you. I may also share this information with others to arrange payment for your treatment.

By signing this form you are agreeing to let me use your information here and share it with the others as mentioned above. The Notice of Privacy Practices/Patients' Rights explains in more detail your rights and how I can use and share your information. Please read this carefully before your sign this consent form.

If you do not sign this consent for agreeing to what is in my Notice of Privacy Practices/Patients' Rights I cannot treat you.

In the future, I may change how I use and share your information and so may change my Notice of Privacy Practices/Patients' Bill of Rights. If I do change it, you will be notified, and can get an updated copy from me.

If you are concerned about some of your information, you have the right to ask me to not 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 do as you asked.

After you have signed this consent, you have the right to revoke it in writing. I will comply with your wishes about using or sharing your information from that time on, but may already have used or shared some of your information and cannot change that.

_____ _____
Signature of client (or personal representative Date

_____ _____
Printed name of client (or personal representative) Relationship to client

_____
Description of personal representative's authority (if necessary)

_____
Signature of Treating Therapist

Date of NPP_____ ____Copy given to client/guardian/personal representative