W. Laura Hawk, Ph.D., LLC
Counseling Psychologist

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PATIENT CONSENT FORM

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information.

When I am diagnosed, treated, or referred, what the law calls **Protected Health Information** (PHI) is being collected. This information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple health care providers who may be involved in my treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct health care operations such as quality assessments and physician certifications.

I have been informed by W. Laura hawk, Ph.D., LLC of the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing the restriction of the use of my private information to carry out payment, treatment, or health care operations. I also understand your office is not required to agree to my requested restrictions, but if an agreement is made by W. Laura Hawk, Ph.D., LLC, the restrictions are binding.

I understand that I may revoke this consent in writing at any time, except to the extent that action has been taken relying on this consent.

Patient Name_____

Signature_____

Relationship to Patient_____Date_____