

Lakewood Counseling

Consent to use Disclosure of Healthcare Information for Treatment, Payment, or Healthcare Operations

This notice describes how Psychological and Medical information about you may be used and disclosed. Please review it carefully.

By signing this statement, I understand that as a part of my health care, Lakewood originates and maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care or treatment. This information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that as part of Lakewood's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I wish to have the following restrictions to the use or disclosure of my health information:

(Please list any restrictions)

I fully understand and accept the terms of this consent.

Client's Signature

Legal Guardian /Relation to Client Date

A copy of *Notice of Privacy Practices* that provides a more complete description of all information uses and disclosures has been made available to me. I fully understand and accept the terms listed in that document including my rights and privileges as a client of Lakewood Counseling.

Client's Signature

Legal Guardian /Relation to Client Date

