Kasandra Wheeler, PLLC
LICENSED PROFESSIONAL COUNSELING

# Consent to Use and Disclose Your Health Information

This form is an agreement between you, _____, and me, Kasandra Wheeler. When we use the words "you" and "your" below, this can mean you, your child, or a person for whom you are the legal or personal representative if you have written his or her name here: _____.

When we examine, evaluate, diagnose, treat, or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide what treatment is best for you and to provide this treatment to you. We may also share this information with others to arrange payment for your treatment, to help others provide other treatment to you, or to carry out certain business or government functions.

By signing this form, you are agreeing to let us use your PHI here and to send it to others for the purposes described just above. Your signature below acknowledges that you have read or heard our Notice of Privacy Practices, which explains in more detail what your rights are and how we can use and share your information. If you do not sign this form agreeing to our privacy practices, we cannot treat you, because we need to use your PHI to evaluate, diagnose, and treat you.

In the future, we may change how we use and share your PHI, and so we may change our Notice of Privacy Practices. If we do change it, you will receive a copy of the updated version.

After you have signed this consent, you have the right to revoke it by writing to our office. We will then stop using or sharing your PHI, but if we have already used or shared some of it, and we cannot change that.

_____ ___/___/___

Signature of client or personal representative — Date

_____ _____

Printed name of legal representative — Relationship to client

_____ ___/___/___

Signature of authorized representative of this office or practice — Date