Annette Hodgson, LCSW

HIPAA Consent for Purposes of Treatment, Payment & Healthcare Operations (3/03)

In this document, "I" and "my" refer to the client, and "AH" refers to Annette Hodgson, therapist.

I consent to the use or disclosure of my protected health information by AH for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of AH. I understand that analysis, diagnosis or treatment of me by AH may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. AH is not required to agree to the restrictions that I may request. However, if AH agrees to a restriction that I request, the restriction is binding on AH. I have the right to revoke this consent, in writing, at any time, except to the extent that AH has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my therapist/counselor, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the HIPAA Notice of Privacy Practices and understand that I have a right that Notice 's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of AH. This Notice of Privacy Practices also describes my rights and duties of AH with respect to my protected health information.

AH reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of AH and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Print Client Name:_____

Client's Signature:_____ Date:_____

Signature of Personal Representative:_____ Date:_____

Personal Representative's Authority: _____
(Parent, Legal Guardian, Attorney, etc)

Revised: 8/09