COASTAL NEUROPSYCHOLOGY

BRAIN & BEHAVIOR SPECIALISTS

USE AND DISCLOSURE CONSENT

Client:_____ Date of Birth: _____/_____/_____

I give permission for the following items to Coastal Neuropsychology by marking each:

_____ To use Protected Health Information within Coastal Neuropsychology for the purpose of my treatment.

_____ To disclose Protected Health Information as necessary to my insurance carrier.
If this is not approved, I understand that my insurance will not be filed and I will be responsible for 100% of all charges.

_____ To share Protected Health Information with my Referring Physician.

_____ I understand that as part of Coastal Neuropsychology's treatment, payment, or healthcare operations it may become necessary to disclose my Protected Health Information to another entity (whom is bound to utilize all Privacy Laws) and I consent to such disclosure.

Please list, if any, person(s) whom we may discuss about your medical condition, diagnosis, and/or financial account:

Name:_____ Phone: (_____)_____

Name:_____ Phone: (_____)_____

I understand that this authorization can be revoked at any time by submitting a written request of revocation to Coastal Neuropsychology. We will then stop sharing your information; however, if we have already used or shard some of it, this cannot be changed.

I understand that if I refuse to sign this authorization, Coastal Neuropsychology may not be able to treat me.

X_____
Signature of client or responsible party Date

_____
Printed name of client or responsible party