SECTION A: PATIENT GIVING CONSENT

Name:_____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____ - _____ - _____

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read my Notice of Privacy Practices before you decide whether to sign this Consent. The Notice provides a description of my treatment, payment activities, and healthcare operations, of the uses and disclosures I may make of your protected health information, and of other important matters about your protected health information. A copy of my Notice accompanies this Consent. I encourage you to read it carefully and completely before signing this Consent.

I reserve the right to change my privacy practices as described in our Notice of Privacy Practices. If I change my privacy practices, I will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that I maintain. You may obtain a copy of my Notice of Privacy Practices, including any revisions of my Notice, at any time by contacting:

Contact Person: David Stroud, LPC
Telephone: 972-674-9511
E-mail: david.t.stroud@gmail.com
Address: 3028 Communications Pkwy, Suite 300, Plano, TX 75093

Right to Revoke: You will have the right to revoke this Consent at any time by giving me written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action I took in reliance on this Consent before I received your revocation, and that I may decline to treat you if you revoke this Consent.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative's Name:_____
Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN Consent to Use and Disclose Health Information.