ADELE MACKAY, PSY.D.

CLINICAL PSYCHOLOGIST

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

PATIENT Name: ____

Federal regulations (HIPAA) allow us to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for services Dr. MacKay provides, and for other professional activities (known as health care operations). Nevertheless, we ask your consent in order to make this permission explicit. The Notice of Policies and Practices for the Privacy of Your Health Information (PHI) describes these disclosures in more detail. You have the right to review the Notice of Policies and Practices for the Privacy of Your Health Information before signing this consent. We reserve the right to revise the Notice of Policies and Practices for the Privacy of Your Health Information at any time. If we do so, the revised notice will be posted in Dr. MacKay's office and on her website. You may ask for a printed copy of that Notice at any time.

You may ask Dr. MacKay to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment or health care operations. However, she does not have to agree to those restrictions. If she does agree to a restriction, that agreement is binding.

You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to revocation.

This consent is voluntary. You may refuse to sign it. However, Dr. MacKay is permitted to refuse to provide health care services if this consent is not granted, of if the consent is later revoked.

I hereby consent to the use or disclosure of my Protected Health Information (PHI) as specified above.

Patient's Signature: ____ Date: _____________