



8008 SLIDE RD. #31 LUBBOCK, TEXAS 79424  
(806) 300-0898 OFFICE (806) 701-5422 FAX

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*Consent to Use and Disclose Your Health Information*

This form is an agreement between you, \_\_\_\_\_, and Rise Counseling. When I use the words “you” and “your” below, this can mean you, your child, a relative, or some other person if you have written his or her name here: \_\_\_\_\_.

When I meet with, assess, diagnose, treat, or refer you, I will be collecting what the law calls “protected health information” (PHI) about you. I need to use this information in my office to decide on what treatment is best for you and to provide treatment to you. I may also share this information with others to arrange payment for your treatment, to help carry out certain business functions, or to help provide other treatment to you.

By signing this form, you are also agreeing to let me use your PHI and to send it to others for the purposes described 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 the privacy practices, I cannot treat you.** In the future, I may change how I use and share your information, and so I may change our notice of privacy practices. If I do change it, you can get a copy from my office or by calling me at 806-300-0898.

If you are concerned about your PHI, you have the right to ask me not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to accept these limitations. However, if I do agree, I promise to do as you asked. This could prevent you from using your health insurance to pay for your treatment.

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

\_\_\_\_\_  
Signature of client or his or her personal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of client or personal representative

\_\_\_\_\_  
Relationship to the client

\_\_\_\_\_  
Description of personal representative’s authority

\_\_\_\_\_  
Signature of authorized representative of this office or practice

Date of NPP \_\_\_\_\_

\_\_\_\_\_ Copy given to the client/parent/personal representative