Helen G. Jenne, Psy.D., LLC
Psychologist
Board Certified in Clinical Psychology

Consent to Use or Disclose Protected Health Information

This form is an agreement between you, _____ and Dr. Jenne. When I use the word "you" below, it will mean your child, relative, or other person if you have written his/her name here_____.

When I examine, diagnose, treat, or refer you I will be collecting what the law calls Protected Health Information (PHI) about you. I need this information here to decide on what treatment/evaluation is best for you and to provide treatment/evaluation to you. I may also share this information with others who provide treatment to you or need it to arrange payment for your treatment/evaluation or for other business or government functions.

By signing this form you are agreeing to let me use your information here and send to others. The Notice of Privacy Practices explains in more detail your rights and how I can use and share your information. Please read this before you sign the consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.

In the future I may change how I use and share your information and so may change my Notice of Privacy Practices. If I do not change it, you can get a copy from me by calling me at 404-419-6282.

If you are concerned about some of your information, you have the right to ask me not to use or share some of your information 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 agree to these limitations. However, if I do agree, I agree to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling me you no longer need consent) and I will comply with your wishes about using or sharing your information from that time on but I may already have used or shared some of your information and cannot change that. By signing this consent, I consent to Dr. Jenne's use or disclosure of my individually identifiable health information for the purpose of treatment, payment, or health care operations.

_____ _____
Signature of client or his/her personal representative Date

_____ _____
Printed Name of client or personal representative Relationship to client