STEVEN REISLER, PSY.D.

CONSENT TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

As a condition of providing treatment to you, **STEVEN REISLER, PSY.D.** may request your consent to use and disclose protected health information about you to carry out treatment, payment, and health care operations.

You may revoke this consent at any time by notifying **STEVEN REISLER, PSY.D.** *in writing*, except to the extent that the provider has taken action and reliance on your consent.

Please refer to the Notice of Privacy Practices for Protected Health Information ("Privacy Notice") for a more complete description of the uses and disclosures that **STEVEN REISLER, PSY.D.** may use of your protected health information. You have the right to review the Privacy Notice prior to signing this consent.

STEVEN REISLER, PSY.D. has reserved the right to change its privacy practices described in this Privacy Notice. In accordance with law, the terms of the Privacy Notice may change. At any time, you may obtain a copy of the current Privacy Notice and any revised notice.

You have the right to request that **STEVEN REISLER, PSY.D.** restrict the manner in which your protected health information is used or disclosed to carry out treatment, payment, or health care operations. The provider is not required, however, to agree to such requested restrictions. If, however, the provider agrees to the requested restriction, the provider will honor the request and it will be binding.

I hereby consent to the use and disclosure by my provider, its workforce, and its business associates of my protected health information for purposes of treatment, payment, and health care operations.

_____ _____

Signature of Client **Date**

_____

Print Client's Name