Barbara Cadow, Ph.D.
PSY6165
10921 Wilshire Boulevard, Suite 507
Los Angeles, CA 90024
(310) 824-3500

Patient Consent For Use and Disclosure of Protected Health Information

Patient Name: ________________________________ Date: ______________________

With my consent, the practice of Barbara Cadow, Ph.D. may use and disclose health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO) in accordance with the Health Insurance Portability and Accountability Act (HIPAA). Please refer to Barbara Cadow, Ph.D. Notice of Privacy Practices for a more complete description of such disclosures.

There are some situations in which I am legally obligated to take actions. These situations are unusual in my practice. If such a situation arises, I will limit my disclosure to what is necessary.

HIPAA provides you with several new or expanded rights with regard to your disclosures of PHI. These rights include requesting that I amend your record; requesting restrictions on what PHI is disclosed to others; requesting an accounting of disclosures of PHI that you have neither consented to nor authorized; determining the location to which PHI disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement and my privacy policies and procedures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Barbara Cadow, Ph.D. reserves the right to revise the Notices of Privacy Practices at anytime. A revised Notice of Privacy Practice may be obtained by forwarding a written request to Barbara Cadow, Ph.D., at the above address.

With my consent, Barbara Cadow, Ph.D. may call my home or other designated location and leave a message on voice mail or in person or in email in reference to any items that may assist her practice in carrying out TPO, such as appointments, insurance items and any calls pertaining to my clinical care. With my consent, she may mail to my home or other designated location, including email, any items that assist in carrying out TPO, such as patient or billing statements.

I have the right to request that Barbara Cadow, Ph.D. restrict how she uses or discloses my PHI to carry out TPO. However, she is not required to agree to my requested restrictions, but if she does, she is bound by this agreement.

By signing this form, I am giving my consent to Barbara Cadow, Ph.D. to use and disclose PHI in order to carry out TPO.

I may revoke my consent in writing except if the she has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Barbara Cadow, Ph.D. may decline to provide treatment to me.

______________________________ ______________________________

Signature of Patient/Parent/Guardian Print Name of Authorized Signer