Consent to Use and Disclose Your Health Information
Lancaster Psychotherapy

This form is an agreement between (client)_____, and Susan Cabouli, Ph.D. When I use the words "you" and "your" below, this means you, your child, or a person whom you legally or personally represent if you have written his or her name here:_____.

When I examine, evaluate, 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 what treatment is best for you and to provide this treatment to you. I may also share your PHI with others to arrange payment for your treatment, help others provide other treatment to you, or carry out certain business or government functions.

By signing this form, you are agreeing to let me use your PHI here and send it to others for the purposes described above. Your signature below acknowledges you have read or heard my Notice of Privacy Practices (NPP), which explains in more detail what your rights are and how I can use and share your information. If you do not sign this form agreeing to my privacy practices, I cannot treat you because I need to use your PHI to evaluate, diagnose and treat you.

In the future, I may change how I use and share your PHI, so I may change my NPP. If I do change it, you can get a copy of it from my website at lancasterpsychotherapy.com or from me. I can be reached at (717) 475-7263.

You have the right to revoke this consent by writing to me. I will then stop using or sharing your PHI, but I cannot revoke your PHI that I have already used or shared.

_____ _____

Signature of client or personal representative Date

_____ _____

Printed name of legal representative Relationship to client

_____

Susan Cabouli, Ph.D, Clinical Psychologist, License #PS006748L Date

Copy given to the client/parent/personal representative_____ Date of NPP 10/1/2017