ELLIOTT M. STRICK, MA, LMFT

West Hartford Therapy Center LLC

10 North Main Street, Suite 214 **860-231-8459**

West Hartford, CT 06107 **www.elliottstrick.com**

Consent for Use and Disclosure of Protected Health Information (HIPPA)

Purpose of Consent: By signing this form, you will consent to my use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. You are also agreeing to my contacting you by phone, mail, text or email if requested, about appointment times or other related health information that may be of interest to you. If this contact is made by phone and you are not available a message will be left on your answering device.

Notice of Privacy Practices: You have the right to read my Notice of Privacy Practices before you decide whether to sign this Consent. My Notice provides a detailed description of the uses and disclosures I may make of your protected health information.

Some of the circumstances in which I may have to use or disclose your health information are:

- I may have to disclose your health information to another health care provider or hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- I may have to disclose your health information and billing records to another party (i.e. insurance carrier) if they are potentially responsible for the payment of your services.

A copy of my Notice of Privacy Practices, including any revisions, is available in my office at all times and may be obtained by request in person, by phone or in writing. I reserve the right to change my privacy practices as described in my Notice of Privacy Practices.

You have the right to request that I do not disclose your health information to specific individuals, companies, or organizations. If you would like to restrict the use or disclosure of your health information, please let me know in writing. I am not required to agree to your restrictions, however if I do agree with your restriction then it is binding on me.

Right to Revoke: You have the right to revoke this consent at any time by giving me written notice, except to the extent of any action that I have taken based upon your prior consent. If you do not sign this consent, I have the right to decline to treat you or to continue treating you.

I have read this consent form and agree to its terms.

Printed name	Signature	Date
Printed name	Signature	Date

Effective date of this Notice 4/14/03