Tiffany Griffiths, Psy.D. & Associates, Inc.

CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This form is an agreement between you, _____, and Tiffany Griffiths, Psy.D. & Associates, Inc. "You" will mean your child, relative, or other person, if you have written his/her name here _____.

When your clinician evaluates, diagnoses, treats, or refers you, she/he will be collecting what the law calls "Protected Health Information" (PHI) about you. Your clinician needs to use this information to decide on what treatment is best for you and to implement that treatment. Your clinician may also share this information with others who provide treatment to you or need it to arrange payment for your treatment by a third party payor (i.e., health insurance company, billing department, etc).

By signing this form, you are agreeing to let your clinician use your information and send it to others as stated above. The Notice of Privacy Practices (NPP) posted in the office explains in more detail your rights and how your information is used and shared. Please read this before you sign this consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices you cannot be treated by your clinician.

In the future how your information is used and shared may change and so may our Notice of Privacy Practices. If this occurs, you can get a copy by calling (570) 342-8434.

If you are concerned about some of your information, you have the right to ask your clinician not to use or share some of your information for treatment, payment, or administrative purposes. You will have to give this information in writing. Although every effort will be made to respect your wishes Tiffany Griffiths, Psy.D. & Associates, Inc. is not required to agree to any limitation set forth by you. However, if your request is agreed to, compliance will occur.

After you sign this consent, you have the right to revoke it by writing a letter stating that you no longer consent to the use and disclosure of your information. Tiffany Griffiths, Psy.D. & Associates, Inc. will comply with your wishes from that time on, but some information may have already been used or shared.

_____ _____

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

_____ _____

Printed name of client or parent/personal representative Relationship to the client