

# Hope Performance Systems LLC

## Consent to Use and Disclose Personal Health Information

I, \_\_\_\_\_, do hereby enter into an agreement between myself and Hope Performance Systems LLC (If I am serving as the legal representative of another client, their name is listed here: \_\_\_\_\_).

I understand that when my therapist or psychiatrist at Hope Performance Systems LLC examines, treats, or refers me, she will be collecting what the law calls Protected Health Information (PHI). I understand that this information is needed to keep a file about me and/or others involved in my treatment, and that it may be necessary to share my PHI with other people or organizations necessary to provide treatment for me, arrange for payment of services, or for administrative purposes. I have been informed that the NOTICE OF PRIVACY PRACTICES explains in more details my rights and in what way my PHI can be used.

**I acknowledge that if I do not sign this Consent Form agreeing to what is in the Notice of Privacy Practices, that my therapist and/or other representative of Hope Performance Systems LLC cannot treat me.**

I understand that if I am concerned about some of my Personal Health Information, I have the right to ask my therapist or other representative of Hope Performance Systems LLC, not to share some of this information for treatment, payment, or administrative purposes. I realize that Hope Performance Systems LLC and its representatives will try to respect my wishes, but that they are not required to agree to these limitations. However, if Hope Performance Systems LLC or its appropriate representative does agree, Hope Performance Systems LLC promises to comply with my wishes.

After I have signed this consent, I have the right to revoke it (by submitting a written letter stating I no longer consent to these terms) and that Hope Performance Systems LLC will comply with my wishes about using or sharing my PHI information from that time on. I realize that if Hope Performance Systems LLC has already shared some of my PHI, this cannot be changed.

Signature of Client /Their Personal Representative/Legal Guardian: \_\_\_\_\_

Printed Name of Client: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

Date: \_\_\_\_\_

Agency Representative Name: \_\_\_\_\_

Agency Representative Signature: \_\_\_\_\_

Date: \_\_\_\_\_