Nedra Koenig, M.A.
Licensed Marriage & Family Therapist

CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This form is an agreement between you, ___________________________ and me, Nedra Koenig.
When I use the word "you" below, it can mean you, your child, a relative, or other person if you have written his/her name here ____.

When I examine, test, diagnose, treat, or refer you, I will be collecting what the law calls Protected Healthcare Information (PHI) about you. I need to use this information to decide on what treatment is best for you and to provide any treatment to you. I may also share this information with others who provide treatment to you or need to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let me use your information here and send it to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Copies of the Privacy Practices are available for you to read. Please make the time to review them before signing this consent form.

If you do not sign this consent form agreeing to what is in the Notice of Privacy Practices, I cannot treat you.

In the future, I may change how I use and share your information and so may change my Notice of Privacy Practices. If I do change it, you can get a copy from me or by calling me at (317) 564 - 8610.

If you are concerned about some of your information, you have the right to ask me to not use or share some of your information for treatment, payment or administrative purpose. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to agree to these limitations. However, if I do agree, I promise to do as you asked.

After you have signed this consent, you have the right to revoke it (by writing a letter to me telling me you no longer consent). I will comply with your wishes about using or sharing your information from that time on, but I may already have used or shared some of your information and cannot change that.

____ ________________
Signature of client or his/her personal representative Date

____ ________________
Printed name of client of personal representative Relationship to client

____ ________________
Signature of authorized representative of this office/practice Date

Revised: 01/10/2014

340 N. Rangeline Road, Carmel, IN 46032
Phone: 317.564.8610 Fax: 317.815.9223