HIPAA Consent to Use and Disclose Health Information

By signing this form, I acknowledge that I have received a copy of Emily Klik LMT CST's Notice of Privacy Practices *(this form can be found on Emily Klik's website).*

-I request the following restrictions to the use or disclosure of my health information:

_____

_____

Signature_____ Date _____

Printed Name:_____

Client Date of Birth:_____

Client Name if signing for a minor child: _____

It has been my experience that some clients prefer email correspondence regarding their own or their child's care. Emily Klik does NOT have HIPAA-compliant (encrypted) email service. With this understanding, please initial:

_____I give my permission to correspond by email regarding my/my child's care and appointments.

_____I prefer phone correspondence only. These may include text messages.

If we are unable to speak with you directly by phone, is it okay for Emily Klik to leave detailed/clinical information and/or appointment reminders on your answering machine, if available?

____Yes ____No _____ Appointment reminders only

Release of Information (OPTIONAL)

I authorize Emily Klik LMT CST to release and/or discuss medical/healthcare information with:

_____ Relation:_____

_____ Relation:_____

The following individuals or facilities, in order to coordinate care:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Signature:_____