DR. MICHAEL REITER, LLC
LICENSED PSYCHOLOGIST
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CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This form is an agreement between you,_____ and me, Michael Reiter, Ph.D. When I use the words "you" and "your" below, this can mean you, your child, your relative, or some other person if you have written his or her name here: _____.

When I examine, test, diagnose, treat, or refer you, I will be collecting what the law calls "protected health information" (PHI) about you. I need to use this information to decide on what treatment is best for you and to provide treatment to you. I may also share this information with your insurance company to help provide treatment for you.

By signing this form, you are agreeing to let me use your PHI and to send it to your insurance company for the purposes described above. Your signature below acknowledges that you have read or heard my notice of privacy practices, which explains in more detail what your rights are and how I can use and share your information.

If you do not sign this form agreeing to my privacy practices, I cannot treat you (or your child if your child is the patient). In the future, I may change how I use and share your information, and so I may change my notice of privacy practices. If I do change it, I will give you the revised practices.

If you are concerned about your PHI, you have the right to ask me not to use or share some of it for treatment, payment, or administrative purposes. Please provide this information in writing. Although I will try to respect your wishes, I am not required to accept these limitations. After you have signed this consent, you have the right to revoke it by written request.

_____

Signature of client or his/her personal representative Date

_____

Printed name of client or representative Relation to client