LISA M. STEPHEN, Ph.D., P.C.

Licensed Psychologist – Doctorate

89 Rye Circle, Suite 1 South Burlington, VT 05403 • Ph (802) 355-9299 • Fax (802) 419-3399

Client Last Name:	Client First Name:	DOB:	Date:

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI) – ADULT

This form is an agreement between you, _____, and Lisa M. Stephen, Ph.D.
Client's Name

When I assess, 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 here to decide on what treatment is best for you and to provide treatment to you. I may also share this information with others who provide treatment to you, need PHI to arrange payment for your treatment, or need PHI for other business or government functions.

In the future I may change how I use and share your information and may change my Notice of Privacy Practices. If I do change it, you can get a copy from me by asking in person or calling me at (802) 355-9299.

If you are concerned, you have the right to ask me in writing not to use or share some of your information for treatment, payment or administrative purposes. Although I will try to respect your wishes, I am not required to agree to these limitations. However, if I do agree, I will comply with your request within the legal limits of federal and state laws.

After you have signed this consent, you have the right to revoke it by writing a letter telling me you no longer consent. I will comply with your wishes about using or sharing your information within the legal limits of federal and state laws from the date I receive your letter. However, I may already have used or shared some of your information and cannot change that.

Signatures (To be signed in session. Please note, in compliance with the law, if you do not sign this consent form agreeing to what is in my Notice of Privacy Practices, I cannot treat you because I need your PHI to evaluate, diagnose and treat you.)

My signature below indicates the following: I give my permission for Dr. Stephen to use my PHI and to send it to the professionals and organizations necessary so that she can bill her services. I read and reviewed the content of this statement with Dr. Stephen and I consent to its provisions. I understand that Dr. Stephen will comply with HIPAA and all applicable federal and state laws. I have read the long version of the Notice of Privacy Practices and I have been given a copy of it or declined a copy and was then informed how to access one in the future. I understand and agree to comply with the Notice of Privacy Practices.

	Signature	Printed Name	Date
Client			
Parent/Guardian			
Parent/Guardian			
Witness		Lisa M. Stephen, Ph.D.	

❑ *Copy of NPP given to the client* ❑ *Client declined copy of NPP and was informed how to access it.*