Gary M. Eisenberg, Ph.D.

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Consent for treatment and to use and disclose your health information

Consent to use and disclose your health information

This form is an agreement between you, _____ (client or parent or guardian) and me/us (check box) □ Dr. Gary M. Eisenberg or □ Dr. Neil I. Fried. When we use the word "you" below, it will mean your child, relative, or other person if you have written his or her name here_____(child's name).

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

By signing this form, you are agreeing to let us use your information here and send to the insurance company and your primary physician. This is not likely to apply to those paying fee-for service (without insurance benefits). The Notice of Privacy Practices (NPP) explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent form.

If you do not sign this consent form agreeing to what is on our Notice of Privacy Practices, we cannot treat you. In the future, we may change how we use and share your information and so may change our Notice of Privacy Practices. If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish.

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

_____ _____
Signature of client or parent or guardian Date

_____ _____
Printed name of client or parent or guardian Relationship to the client

I understand that the above means that limited information (e.g. diagnosis, symptoms, treatment plans, treatment progress) can be shared with your insurance company and primary care physician.

_____
Initial Here