



Childhood Language Center

A tax-deductible non-profit organization

406 Capitol St. Charleston, WV 25301-1717

Phone 304 342-7852 or 888 228-7852 Fax 304 342-2970

HIPAA CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT AND HEALTH CARE OPTIONS

Federal regulations (HIPAA) allow us to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, and for other professional activities (known as "health care operations"). Nevertheless, we ask your consent in order to make this permission explicit. The Notice of Privacy Practices describes these disclosures in more detail. You have the right to review the Notice of Privacy Practices before signing this consent. We reserve the right to revise our Notice of Privacy Practices at any time. If we do so the revised Notice will be posted in the office. You may ask for a printed copy of our Notice at any time.

You may ask us to restrict the use and disclosure of certain information in your records that otherwise would be disclosed for treatment, or health care operations: however, we do not have to agree to these restrictions. If we do agree to a restriction, that agreement is binding.

You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation.

This consent is voluntary: you may refuse to sign it. However, we are permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked.

I hereby consent to the use or disclosure of my protected health information as specified above.

Patient name _____

Signature of Parent or
Guardian _____ Date: _____