20231 Paint Boulevard
Shippenville, PA 16254
(814) 226-1159
Fax (814) 227-2876

850 Leonard Street
Clearfield, PA 16830
(814) 205-4004
Fax (814) 205-4013

PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES AND THE CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This form is an agreement between you and Project Point of Light. When I use the word "you" it will mean you, your child or other person you may have guardianship of.

When we examine, treat, diagnose, or refer you we will be collecting what the law calls Protected Health Information (PHI). We need to use this information 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 governmental functions. By signing this form you are agreeing to let us use your information and send it to others for the purposes described above. Your signature below acknowledges that you have been provided a copy of our Notice of Privacy Practices under HIPAA, which explains in more detail what your rights are and how we can use and share your information.

If you do not sign this consent form agreeing to what is in 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 we do change it, you can get a copy by contacting the office directly and asking to speak with the Privacy Officer. If you are concerned about your PHI, you have the right to ask us to not use or share some of this 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 to our Privacy Officer. We will then stop using or sharing your PHI, however we may already have used or shared some of your information and cannot change that. If you have a complaint regarding the use of your PHI please contact our Privacy Officer who will assist you in the complaint process.

_____

Client's Printed Name

_____ _____

Client's Signature (Parent/Guardian Signature if Child Under 14) Date

_____

Therapist's Signature Credentials

Client Name: Client ID: