696 Mt. Zion Road • Suite 3B • Jonesboro • GA 30236
TEL 404-381-4108. • FAX 404-381-3043
POSITIVEOUTLOOK.CLINIC@GMAIL.COM

HIPPA 2013

I consent to the use or disclosure of my protected health information by Provider for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Speech-Language Pathology. I understand that analysis, diagnosis or treatment of me by Positive Outlook may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Provider is not required to agree to the restrictions that I may request. However, if Provider agrees to a restriction that I request, the restriction is binding on Provider.

I have the right to revoke this consent, in writing, at any time, except to the extent that Provider has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Provider and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Provider. The Notice of Privacy Practices for Provider is also posted in the office at above address. This Notice of Privacy Practices also describes my rights and duties of the Provider with respect to my protected health information.

Provider reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Provider and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment. Photo of client is a procedural policy for treating in a manner that conducts health care operations according to Positive Outlook.

Signature of Guardian/Patient – Firma del padre ____________________________________

Printed Name of Patient / Nombre del niño(a) ____________________________________

Date of Signing / Fecha ____________________________________