Consent to use and disclose your health information

NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt

The Notice of Privacy Practices tells you how we may use or disclose Protected Health Information (PHI) about you. Not all situations will be described. We are required to give you a notice of our privacy practices about your Protected Health Information. When we examine, test, diagnose, treat, or refer you we will be collecting what the law calls Protected Healthcare Information about you. We need to use this information to decide 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.

I, _____ (Patient Name), have been given a copy of Sioux Empire Christian Counseling's Notice of Privacy Practices and understand that I may ask questions about how my PHI will be used.

If you do not sign this consent form, we cannot treat you.

_____ _____

Signature - Patient *Date*

_____ _____

Signature - Legal Representative *Date*

_____

Relationship to Patient

Sioux Empire Christian Counseling
2000 S. Sycamore Ave. Suite 101, Sioux Falls, SD 57110-4263
Phone: 605-271-0261 Fax: 605-271-0263 www.siouxempirechrisiancounseling.com