Triss Fifer, LCSW

Consent of Disclosure

(For the usage and/or Disclosure of Protected Health Information)

I hereby give consent to Triss Fifer, LCSW, to use and disclose my protected health information for the purposes of treatment, payment and health care operations.

You may cancel this consent at any time. Your cancellation must be in writing, signed by you on your behalf and delivered to the address at the bottom of this form. This may be delivered in person or by mail. It will only be effective when I actually receive it. Your cancellation will not be effective to the extent that others or I have acted in reliance upon this consent.

You have the right to request restrictions on the usage and disclosure of your protected health information for the purposes of treatment, payment or health care operations. I am not required to grant your request, however, if I do, the restrictions will be obligatory to me.

My Posted Privacy Policy provides more detailed information about the usage and disclosure of your protected health information. You have the right to review my Posted Privacy Policy before you sign this consent.

I reserve the right to amend the terms of my Posted Privacy Policy. You may obtain a copy of the current policy by requesting a copy from me.

Print Name of Patient:_____

Signature:_____

If you are signing as the patient's representative:

Print Your Name:_____

Relationship:_____

INSTRUCTIONS FOR COMMUNICATION OF PERSONAL HEALTH INFORMATION

I or my billing service, Metropolitan Health Providers Billing Service, may communicate personal health information to you and/or information regarding your account by;

_____ Fax#_____

_____ E-mail Address _____

_____ Answering Machine/Voice Mail #_____

_____ Authorized Person(s) _____ _____

The authorized person(s) listed above May_____/May Not_____ schedule, cancel and confirm appointments for you.

_____ _____

Print your full name Signature Date

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