



### HIPAA Consent to Use and Disclose Health Information

I understand that as part of my / my child's healthcare, this organization originates and maintains health records describing my / my child's health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my / my child's care and treatment
- a means of communication among the many health professionals who contribute to my / my child's care
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

- I agree to disclosure as explained above \_\_\_\_\_
- I request the following restrictions to the use or disclosure of my / my child's health information  
\_\_\_\_\_  
\_\_\_\_\_
- Do you give Wauwatosa Therapies permission to discuss medical information with family members? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please provide their name, relationship, and phone number:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

- May we leave personal medical information on your voice mail? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please provide the phone number where we can leave information \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_