

I-BOS Counseling Center, LLC
Fax: (239) 242-6389

2503 Del Prado Blvd. S. Ste. 410
Cape Coral, Florida 33904

CONSENT TO USE OR DISCLOSE INFORMATION FOR TPO

Patient Name _____

Federal regulations (HIPAA) allow the psychotherapist to use or disclose PHI from your record to provide treatment to you, to obtain payment for the services IBOS provides, and for other professional activities (known as "health care operations"). Nevertheless, IBOS asks for your consent in order to make this permission explicit. The notice of privacy practices describes these disclosures in more detail. You have the right to review the notice of privacy practices before signing this consent. IBOS reserves the right to revise the notice of privacy practices at any time. If done, the revised Notice will be posted in the office and on the website www.iboscounseling.com. You may ask for a printed copy of IBOS's notice at any time.

You may ask IBOS to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or health care operations; however, IBOS does not have to agree to these restrictions. If IBOS does agree to a restriction, that agreement is binding.

You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation.

This consent is voluntary; you may refuse to sign it. However, IBOS is permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked.

I hereby consent to the use or disclosure of my PHI as specified above.

Signature of Client or Legal Guardian: _____

Date: _____

Signature of Client or Legal Guardian: _____

Date: _____

Signature of Client or Legal Guardian: _____

Date: _____

Therapist

Date