Emily Pimpinella, Psy.D.
Clinical Psychologist

Consent to Use and Disclose Your Protected Health Information and Acknowledgement of Receipt of Notice of Privacy Practices

This form is an agreement between you, ______________________________, and me, Emily Pimpinella, Psy.D.

When I examine, test, diagnose, treat, or refer you, I will be collecting what the law calls "protected health information" (PHI) about you. I need to use this information in my office to decide on what treatment is best for you and to provide treatment to you. I may also share this information with others to arrange payment for your treatment by a third party payer (i.e., health insurance companies, billing companies), to help carry out certain business or government functions, or to help provide other treatment to you.

By signing this form, you are agreeing to let me use your PHI and to send it to others for the purposes described above.

Acknowledgement of Receipt of Notice of Privacy Practices: Your signature below also acknowledges that you have received and read/heard my Notice of Privacy Practices, which explains in more detail what your rights are and how I can use and share your PHI. If you have any questions regarding this Notice or your privacy rights, you may discuss this with me.

If you do not sign this form acknowledging and agreeing to my privacy practices, I cannot treat you. In the future, I may periodically change how I use and share your PHI, as the requirements of HIPAA or other pertinent laws change. As such, I will revise my Notice of Privacy Practices promptly to reflect any changes. If this occurs, you can request a copy of the revised Notice by providing me with a written request.

If you are concerned about your PHI, you have the right to ask me not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to accept these limitations. However, if I do agree, compliance will occur.

After you sign this consent, you have the right to revoke it by writing a letter stating that you no longer consent to the use and disclosure of your information. I will then stop using or sharing your PHI; however, some information may have already been used or shared.

______________________________   ______________________

Signature of Client/Client's Representative   Date

______________________________   ______________________

Printed Name of Client/Client's Representative   Date

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Emily Pimpinella, Psy.D., Clinical Psychologist (License #: 019955)

213 North Aurora Street
Ithaca, NY 14850

Phone: 607-273-1083
Fax: 607-273-1183