



3500 N. Causeway Blvd. Ste. 1410  
Metairie, LA 70002  
Phone: (504) 838-9919  
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## Consent to the Use and Disclosure of Health Information for Treatment, Payment and Healthcare Options

I understand that as a part of my health care, my provider, \_\_\_\_\_ originates and maintains mental health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information service is:

- a basis for planning my care and treatment,
- a means of communication among the health professionals who contribute to my care,
- a source of information for applying my diagnosis and treatment to my bill,
- a means by which a third party can verify that services billed were actually provided, and
- a tool for routine mental health care operations, such as assessing quality and reviewing the competence of mental health professionals.

I understand that I have the option of receiving a copy of the Privacy Notification that provides a more complex 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 prior to implementation, and will mail a copy of any revised notice to the address I have provided, if I request.

I understand that I have the right to request restrictions on the use or disclosure of my mental health record for treatment, payment or healthcare options.

I understand that I may revoke this consent in writing at any time, except to the extent that the provider has already taken action in reliance thereon.

No restrictions

I request the following restrictions to the use or disclosure of my health information:

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Signature of Patient or Guarantor

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Date