Columbia Associates in Psychiatry

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

We use information that you provide us, including health information to carry out treatment, payment, and health care operations.

You have the right to restrict the use of your health information to carry out treatment, payment, or health care operations. We are not required to agree to restriction. If we do agree to any restrictions, the agreement is binding on use.

You have the right to revoke this consent at any time by notifying us in writing. The revocation will not have any effect on any actions taken in reliance on the consent prior to time you revoke it.

I hereby consent to the use and disclosure of my individually identifiable health information for treatment, payment, and health care operations purposes. It is our practice to automatically contact your primary physician.

Patient Name (Print)________________________________ Date of Birth_____________

____ _________________________
Signature of Patient or Patient's Representative Date

Name of Primary Care Physician____

Address____

City_____________________ State________ Zip Code_______________________

Phone____

Referred By______________________________________**Organization**__________________

Address____

City_____________________ State________ Zip Code_______________________

Phone____