



NW Medical Hypnosis, LLC

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Consent to Use and Disclose Your Protected Health Information

This form is an agreement between you, and me (Debbie Nesbitt, ARNP) and will become a part of your permanent medical record. When we use the words “you” and “your” below, this can mean you, your child, a relative, or some other person if you have written his or her name here:

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, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let me use your PHI and to send it to others for the purposes described above. **Your signature below acknowledges that you have read or heard my notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.**

To help insure protecting your privacy, please indicate below the preferred ways I may contact you, understanding that messages may contain information about, but not limited to, your treatment, care, payment, and appointments. In giving permission to contact you using one or more of the options outlined below you understand and acknowledge that there may be risks and limitations involved that preclude complete protected exchange of private and/or sensitive information. Selection of one or more contact options indicates agreement on your part that you release myself and NW Medical Hypnosis, LLC from all liability due to unforeseen errors due to transmission methods that do not provide total privacy and security of information. Check the communication options that I can use to contact you:

- Home Phone Cell Phone Work Phone Email Mail to home address

If you do not sign this form agreeing to these privacy practices, I cannot treat you. In the future, I may change how I use and share your information, and so I may change the notice of privacy practices. If I do change it, you can get a copy from my website, www.nwmedicalhypnosis.com, or by calling me at 360-513-9567.

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, I promise to do as you asked. After you have signed this consent, you have the right to revoke it by presenting your request to me in writing. I will then stop using or sharing your PHI, but I may already have used or shared some of it, and I cannot change that.

Signature of client or personal representative

Date

Printed name of client or personal representative

Relationship to the client

Description of personal representative’s authority

Signature of authorized NW Medical Hypnosis, LLC Representative

Date

Copy given to or offered and refused by the client/representative