CONSENT TO USE OR DISCLOSE INFORMATION FOR TPO

Patient Name)			
provide treating professional consent in con	ment to activities order to ese disclices befores at a	you, s (ki ma losul ore s	to obtain to obtain the this res in resigning to the thick the thi	w me to use or disclose PHI from your record in order to ain payment for the services we provide, and for other is "health care operations"). Nevertheless, I ask your permission explicit. The notice of privacy practices more detail. You have the right to review the notice of this consent. We reserve the right to revise our notice of we do so, the revised Notice will be posted in the office. If our notice at any time.
that otherwis	e would do not l	be have	disclos to agr	use and disclosure of certain information in your record sed for treatment, payment, or health care operations; ree to these restrictions. If we do agree to a restriction,
-				t any time by giving written notification. Such revocation reliance on the consent prior to the revocation.
		-	-	ay refuse to sign it. However, we are permitted to refuse if this consent is not granted, or if the consent is later
I hereby cons	ent to th	e us	e or dis	sclosure of my PHI as specified above.
Signature of Date:	Client	or	Legal	Guardian:
	Client	or	Legal	Guardian:
		or	Legal	Guardian:
Therapist				 Date