**Consent For Use and Disclosure Of Health Information**

**SECTION A: Patient Giving Consent**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: (\_\_\_\_ ) \_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_ Social Security:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECTION B:To the Patient - *Please read the following statements carefully***

**Purpose of Consent.** By signing this form, you will consent to my use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

**Notice of Privacy.** You have the right to read my Notice of Privacy before you decide whether to sign this Consent. My Notice provides a description of my treatment, payment activities and healthcare operations, of the uses and disclosures I may make of your protected health information, and of other important matters about your protected health information. A copy of my

notice accompanies this consent. I encourage you to read it carefully and completely before signing this consent.

I reserve the right to change my privacy practices as described in my Notice of Privacy. lf I change my privacy practices, I will issue a revised Notice of Privacy, which will contain the changes, those changes may apply to any protected health information that I maintain. You may obtain a copy of my Notice of Privacy, including any revisions of my notice, at any time from my website or by contacting me at 7325 SW 63rd Ave, Suite 101, Miami FL 33143, or by phone at 305 – 663 – 0584 or by email request sent to CoachRoberta@RobertaGallagher.com.

**Right to Revoke.** You will have the right to revoke this consent at any time by giving me written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action I took in reliance on this consent before I received your revocation, and that I may decline to treat you or to continue treating you if you revoke this consent.

**SIGNATURE**

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.