Laking Therapy Services, LLC
101 Log Canoe Circle Ste C-4
Stevensville MD 21666
410.643.4197

Patient Consent for Use and Disclosure of Protected Health Information Acknowledgement

The United States Department of Health and Human Services has issued *Patient Privacy Regulations*. Prior to commencing your treatment, you should review, sign and date this form.

Your protected health information (i.e. individually identifiable information such as names, dates, phone numbers, addresses, social security numbers, and demographic data) may be used in connection with your treatment or payment of your account.

You have the right to request restrictions on the use of your protected health information. However, we are not required to honor your request.

By signing this consent you understand and agree that because our treatment and/or reception areas may be open, incidental information about you or your child, or your treatment may be overheard by other patients.

We may contact you to provide appointment reminders or information about treatment, treatment alternatives, or other health benefits that may be of interest to you. On occasion, other family members may be privy to that information, through mailings or telephone voice mail messages.

Both parents may request information pertaining to a minor child regardless of which parent the child resides with, unless a written court document restricting such information to one parent only is furnished to our office.

You may revoke this consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this consent.

I have read and understand your **Notice of Privacy Practices** describing the uses and disclosures of my health information. I understand that this office has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this office at any time at the address above to obtain a copy of a current **Notice of Privacy Practices**. If I do not sign this consent Laking Therapy Services LLC may decline to provide treatment to me.

_____
Patient's Signature (Parent for Minor Child)

_____
Print Name of Patient

_____
Date