

DO NOT MAIL - PRESENT THIS FORM TO THERAPIST AT FIRST SESSION

**CONSENT FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION FOR
TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS**

In our Notice of Privacy Practices (“NPP”), we provide you information about how KU Child and Family Services Clinic can use or disclose your health-related information. As described in our Notice of Privacy Practices, we request your consent for use or disclosure of health-related information to carry out treatment, payment, or health care operations. You have a right to review our Notice of Privacy Practices before signing this consent form.

By signing this Consent form, you : (1) Acknowledge that a copy of the Notice of Privacy Practices has been provided to you; and (2) Consent to our use and disclosure of your health information for treatment, payment or health care operations, as described in the Notice of Privacy Practices.

You have the right to revoke this Consent in writing at any time, except where we have already used or disclosed your health information in reliance upon this Consent.

Patient’s Name (Printed)

Date

Signature of Patient/Legal Guardian

Date

Relationship to Client