Client Name _____ Record Number _____

Before your appointment please feel free to review the Notice of Privacy Practices that is provided in the lobby area. This information can also be accessed on our web site at: www.peace-of-mind-inc.com .

Client Consent for Use and Disclosure of Protected Health Information Written Receipt

I hereby give my consent to use and disclose protected health information (PHI) to carry out treatment, payment and healthcare operations (TPO). The Notice of Privacy Practices provided by Peace of Mind, Inc., gives a more complete description of such uses and disclosures.

I have the right to review and receive the Notice of Privacy Practices prior to signing this consent. Peace of Mind, Inc., reserves the right to revise the Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices can be obtained by forwarding a written request to:

Peace of Mind, Inc.
P.O. Box 2088
Lillington, NC 27546

With this consent, Peace of Mind, Inc. may mail to my home or other alternative location any items that assist the practice in carrying out TPO. I am aware that this practice is not required to agree to my restrictions. However, if it does agree to my restrictions, it is bound by the agreement.

By signing this form, I am consenting to Peace of Mind, Inc., use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Peace of Mind, Inc., may decline to provide treatment to me.

Further, I can request a written copy of this notice of privacy practices at any time.

_____ _____
DATE SIGNATURE OF CLIENT/PARENT/LEGAL GUARDIAN

_____ _____
DATE WITNESS