Client/Parent Consent for Use and Disclosure Of Protected Health Information

I hereby give my consent for Diana G. Masker, M. A., C.C.C., Speech and Language Therapy (DGM) to use and disclose protected health information (PHI) about myself/my child to carry out treatment, payment and healthcare operations (TPO). Diana G. Masker, M.A., C.C.C. Speech and Language Therapy's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. DGM reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Diana G. Masker M.A., CCC Privacy at 3040 N. Wickham Rd., Ste. 4, Melbourne, FL 32935.

With this consent, DGM may obtain and/or release protected health information about my/my child's evaluation and/or treatment to other professionals. I will be asked to specify in writing, however, to whom I would like reports and/or other PHI sent and/or from whom I would like information obtained. This information may include, but is not limited to, written evaluation or progress reports, and telephone communication. When possible, DGM will inform me verbally prior to initiating communication with other professionals. I will not necessarily, however, be informed of every communication with my child's teacher if my child is at his/her school.

With this consent, DGM may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my/my child's clinical care. I will be asked to specify in writing, however, to which phone number(s) I would like to receive communication.

With this consent, DGM may mail to my home or other alternative location any items that assist in carrying out TPO, such as client statements.

With this consent, DGM may send communication notebooks or e-mail to my home or other alternative location which assist in carrying out TPO such as homework assignments and may include homework papers, and/or other papers, etc. containing treatment information that may be seen by others.

I have the right to request that DGM restrict how it uses or discloses my PHI to carry out TPO. This request must be made in writing. The practice is not required to agree to my restrictions, however, if it does, it is bound by this agreement.

By signing this form, I am consenting to DGM's 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.

____________________________________ _________________________

Signature of Client/Parent of Legal Guardian Date

____________________________________ _________________________

Print Name of Client/Parent or Legal Guardian Date