Gary R. Elkins, PhD, ABPP

Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of psychological and mental health services, Gary R. Elkins, PhD, hereinafter referred to as Dr. Elkins, creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that Dr. Elkins reserves the right to change the Notice, and will provide me with a copy of any revised notice if requested. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I understand Dr. Elkins may use and disclose my protected health information to provide, coordinate, improve the quality of care for me, or manage my psychological or other mental health services and any related services. This includes the coordination or management of services with a third party that has already obtained permission to have access to my protected health information. For example, Dr. Elkins would disclose protected health information to physicians who may be referring or treating me and protected health information may be provided to a health care or mental health care provider to whom I have been referred to ensure that the provider has the necessary information to diagnose or treat me. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written, oral on in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations as outlined in the HIPPA document without my prior written authorization, except as otherwise provided by law.

2. A photocopy or fax of this consent is as valid as the original.

3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operation, be restricted. I also understand that Dr. Elkins and I must agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information; and I agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

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SIGNATURE (OR GUARDIAN, IF A MINOR) DATE

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(NAME PRINTED)