Northwest Creative Therapy LLC

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Northwest Creative Therapy, LLC

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Consent of Disclosure

(for the usage and/or disclosure of protected health information)

_____ (hereafter referred to as Client) hereby gives consent to Leslie Jones and Northwest Creative Therapy LLC (hereafter collectively referred to as NWCT) to use and disclose client's protected health information for the purposes of treatment, payment and health care operations.

Client may cancel this consent at any time. Cancellation must be in writing, signed by Client, on Client's behalf, and delivered to the address at the bottom of this form. The written cancellation may be delivered in person, or by mail. Cancellation will only take effect when this form is actually received by NWCT. Client's cancellation will not be effective to the extent that NWCT or others have acted in reliance upon this consent.

Client has the right to request restrictions on the usage and disclosure of Client's protected health information for the purposes of treatment, payment or health care operations. NWCT is not required to grant Client's request. However, if NWCT does grant the request the restrictions will be obligatory.

NWCT has established a Posted Privacy Policy which provides more detailed information about the usage and disclosure of your protected health information. Client has the right to review NWCT's Posted Privacy Policy before signing this consent.

NWCT reserves the right to amend the terms of the Posted Privacy Policy. Client may obtain a copy of the current policy by requesting a copy from NWCT.

Print Client's Name: _____

Client's Signature: _____

If you are signing as Client's representative:

Print Your Name:_____

Relationship to Client:_____

Instructions for Communication of Personal Health Information

Leslie Jones and Northwest Creative Therapy LLC may communicate personal health information, or scheduling details, to you and/or information regarding your account by the following methods (please initial and provide information where desired):

_____ Fax Fax #:_____

_____Email Email Address:_____

_____Text

_____ Answering Machine/Voice Mail #:_____

_____ Authorized Person(s): _____

_____ Authorize Telehealth sessions (initialing here is necessary for Telehealth)

The authorized person(s) listed above May ___ / May Not ___ schedule, cancel and confirm appointments for Client. (This primarily pertains to children, when the primary client is under the age of 14)

Print Client's Name: _____

Client's Signature: _____

Date: _____