Consent to Use and Disclose Your Health Information

This form is an agreement between you, (please print your full name here):

_____, and me, S. Ileana Lindstrom, PhD, of Liminal Solutions Psychotherapy and Consulting, LLC. When I use the words "you" and "your" below, this can mean you or a person for whom you are the legal representative if you have written his or her name here:

_____.

When I examine, evaluate, diagnose, treat, or refer you, I will be collecting what the law calls "protected health information" (PHI) about you. I need to use this information in my office to decide what treatment is best for you and to provide this treatment to you. I may also share this information with others to arrange payment for your treatment, to help others provide other treatment to you, or to carry out certain business or government functions.

By signing this form, you are agreeing to let me use your PHI in my office and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard my Notice of Privacy Practices, which explains in more detail what your rights are and how I can use and share your information. If you do not sign this form agreeing to my privacy practices, I cannot treat you, because I need to use your PHI to evaluate, diagnose, and treat you.

In the future, I may change how I use and share your PHI, and so I may change my Notice of Privacy Practices. If I do change it, you can get a copy from my website **www.liminalsolutionspsychotherapy.com** **,** or from me, S. Ileana Lindstrom, PhD, the owner and compliance officer of Liminal Solutions Psychotherapy and Consulting, LLC. You can reach me by phone at 410-699-0093 or by writing and mailing your request to my mailing address: 818 High Street, Suite #4, Chestertown, MD 21620-1152.

After you have signed this consent, you have the right to revoke it by writing to me. I will then stop using or sharing your PHI, but if I have already used or shared some of it, then I cannot change that.

_____ ___/___/___

Signature of client, or client's legal representative (if applicable) Date

_____ _____

Printed name of legal representative (if applicable) Relationship to client

_____

Description of legal representative's authority (if applicable)

_____

Signature of authorized representative of this office and practice

❑ Copy given to the client/client's legal representative Initial: _____

The effective date of the Notice of Privacy Practices is June 21, 2017.