Gabrielle Lawrence, Ph.D.

5040 E. Shea Blvd., #268
Scottsdale, AZ 85254
480-607-5030
gabrl1@cox.net

CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This form is an agreement between you, ____ and *Dr. Gabrielle Lawrence, Ph.D.* When we use the word "you" below, it can mean you, your child, a relative, or other person if you have written his or her name here _________________________ (name of minor or other person).

When we examine, test, diagnose, treat, or refer you we will be collecting what the law calls Protected Healthcare Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide any treatment to you. We may also share this information with others who provide treatment to your or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let us use your information here and send it to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you will be notified at our next session.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to do as you asked.

After you have signed this consent, you have to right to revoke it (by writing a letter to our Privacy Officer telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

____ Date ______________________
Signature of client or his or her personal representative

____
Printed name of client or personal representative Relationship to client

____
Description of personal representative's authority

CLIENT COPY *(please keep copy)*
OFFICE COPY ***(please bring with you)*** **_XX_**

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