PATIENT CONSENT TO SHARE PROTECTED HEALTH INFORMATION

*This form will allow us to leave a message on voicemail or with individuals involved in your health care

PATIENT INFORMATION:

Name of Patient:	Phone Number(s):
Date of Birth:	Address:
Provider Name: **Alexann C. Masiko-Meyer, M.Ed., LPCC, LPC, LCMHC, NCC, PPS**	

I (the undersigned) hereby consent to Alexann C. Masiko-Meyer, M.Ed., LCMHC, PPS, leaving a voicemail message at the number(s) indicated above and /or discussing with the individual(s) listed below information related to my protected health information (PHI). These communications may include, but are not limited to, appointment reminders, medications, pre-registration, billing and insurance items, and any information pertaining to clinical health services.

With my consent, Alexann C. Masiko-Meyer, M.Ed., LPCC, LPC, LCMHC, NCC, PPS may discuss/share my PHI with the following individuals:

Name:	Address:
Relationship:	Phone #:
Info to Share/NOT share:	
Name:	Address:
Relationship:	Phone #:
Info to Share/NOT share:	

I understand the information listed above may be communicated via: fax, photocopy, verbal communication, telephone, voice mail and/or direct mail.

YOUR RIGHTS WITH RESPECT TO THIS CONSENT: I understand that I have the right to revoke this consent at any time by sending a written statement to Alexann C. Masiko-Meyer, M.Ed., LPCC, LPC, LCMHC, PPS, except to the extent Alexann C. Masiko-Meyer, M.Ed., LPCC, LPC, LCMHC, PPS has already made a disclosure in reliance upon my prior consent. Unless revoked, this consent is valid until the expiration date listed below. A photocopy of a signed consent is acceptable, provided that it is apparent that the consent was signed and dated prior to photocopying. I further understand that this consent does not permit the release of my actual medical records to the individual(s) listed above. Such release will only be made if I sign a separate valid authorization.

If I fail to specify an expiration date, event or condition, this consent will be valid for one year.

____
Expiration Date / Event / Condition

(use drawing tool)

Signature of Patient or Legal Representative

Date

(If signed by Legal Representative, state relationship and authority to do so)

Signature of Witness

Patient is: ___Minor ___Incompetent ___Disabled ___Deceased
Legal Authority: ___Custodial Parent ___Legal Guardian ___Executor of Estate of Deceased ___Authorized Legal Representative (*documentation may be required)

Received by:____ Date:___________________