Loving The Self Therapeutic Services LLC

Consent for Use and Disclosure of Personal Health Information

This form authorizes Dr. Micheal Kane to use and disclose your protected health information (PHI) for the purposes of healthcare operations, treatment and payment for services.

Information on our Notice of Privacy Policies is available for your review.

Patient Name: ____

Patient/Guardian Signature: ______________________________________

Date: ____

Consent to Leave Health Information

_____	May leave message on voicemail at home.	Phone #	______________
_____	May leave message on voicemail at work:	Phone #:	______________
_____	May leave information with spouse.	Name:	______________
_____	May leave information with other family member	Name:	______________
_____	May leave message on cellular phone:	Phone #:	______________
_____	May leave message at different location	Phone#:	______________

With my signature below I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify my healthcare provider should I change any of the phone numbers listed above.

____ ______________________

Patient/Guardian Date

If this consent is signed by the patient's guardian or parent, please complete the following:

Guardian Name: ____

Relationship to Patient: ________________________ Date: ________________