Michael Feeley, PhD
Licensed Psychologist

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Consent to Use and Disclose Your Health Information

This form is an agreement between you, _____, and me, Michael Feeley, PhD.

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 practice and to send it to others for the purposes described just 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 [https://drmichaelfeeley.com], or a paper copy from me, the compliance officer, (Michael Feeley, PhD). I can be reached by phone at 1-888-933-3539 and by email at info@drmichaelfeeley.com].

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

Client name: _____

Client signature: _____

Date: _____

Therapist name: Michael Feeley, PhD

Therapist signature: _____

Date: _____

❑ Copy given to the client

Date of NPP: 2020.August.24