

Uptown Psych Behavioral INC.

HIPPA CONSENT FORM

Consent to Use and Disclose your Health Information

This form is an agreement between you, and me/us. When we below, this can mean you, your child, a relative, or some other her name here:	r person if you have written his or
When we examine, test, diagnose, treat, or refer you, we will be "protected health information" (PHI) about you. We need to use decide on what treatment is best for you and provide treatment information with others to arrange payment for your treatment or government functions, or to help provide other treatment to also agreeing to let us use your PHI and to send it to others for Your signature below acknowledges that you have read or health which explains in more detail what your rights are and how we information.	se this information in our office to t to you. We may also share this t, to help carryout certain business you. By signing this form, you are the purposes described above. and our notice of privacy practices,
If you do not sign this form agreeing to our privacy practices, we cannot treat you. In the future, we may change how we use your information, how we share your information, and may change our notice of privacy practices. If we do change it, you can get a copy from our website, www.uptownpsych.com, or by calling us at (773)989-2780. If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing and have it submitted to us. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as asked. After you have signed this consent, you have the right to revoke it by writing to our privacy officer. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.	
Signature of Patient: Printed Name of Patient:	Date:
Printed Name of Patient:	
If Patient is under 18 years of age:	
Signature of Parent/Guardian:	
Signature of Parent/Guardian: Printed Name of Parent/Guardian: Relationship to Patient:	