DOUG GIRARD, Psy.D.
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RECEIPT OF HIPAA PRIVACY NOTICE

I hereby give my consent for Doug Girard, Psy.D. to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations. Note: The Notice of Privacy Practices provided by Doug Girard describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Doug Girard reserves the right to revise his Notice of Privacy Practices at any time. The latest Notice of Privacy Practices will always be available on Doug Girard's website: **http://www.douggirard.com**.

With this consent, Doug Girard may call my home or other alternative location and leave a message on voice mail in reference to any items that assist the practice in carrying out health care operations, such as appointment reminders, insurance items, and any calls pertaining to my clinical care.

With this consent, Doug Girard may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, Doug Girard may e-mail me any items that assist the practice in carrying out health care operations, such as scheduling notices and payment receipts. I have the right to request that Doug Girard restrict how he uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

PATIENT CONSENT TO PSYCHOTHERAPY

By signing this form, I am consenting to allow Doug Girard, Psy.D. to use and disclose my PHI to carry out health care operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, I understand that Doug Girard may decline to provide treatment to me.

Name of patient: _____

Name of parent/guardian: _____
(if different from above or if patient is a minor)

Signature of patient: _____ Date: _____

Signature of parent/guardian: _____ Date: _____

Therapist Signature: _____ Date: _____