**Sydney E. Felker-Ross, Ph.D.**
Psychologist

***Consent to the Use and Disclosure of Health Information for Evaluation and Treatment, Payment or Healthcare Operations and Acknowledgement of Receipt of Georgia Notice Form for Privacy.***

By signing this form, I give Sydney E. Felker-Ross, Ph.D. permission to use and/or disclose my health information to carry out treatment, payment, or healthcare operations. I understand that services may be refused if I do not sign this Consent. I further understand that as a part of my healthcare, Dr. Felker-Ross originates and maintains health records describing my health history, symptoms, examinations and test results, diagnoses, and treatment information. I understand that this information serves as a:

- Basis for planning my care and treatment;
- Means of communication among health care professionals who contribute to my care;
- Source of information for applying my diagnosis and information to my bill;
- Means by which a 3rd party payer can make decisions about service authorization and/or verify that services were provided;
- Tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Georgia Notice of Health Information Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Dr. Felker-Ross reserves the right to change the notice and practices but prior to implementation will provide me with a copy of any revised notice. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Dr. Felker-Ross is not required to agree to the restrictions requested. I understand that this consent is in effect until I revoke it in writing, to the attention of Dr. Felker-Ross, except to the extent that action has already been taken. If I choose to revoke my consent, I understand that further services may be refused.

Please feel free to discuss and privacy issue or concerns with Dr. Felker-Ross.

□ I wish to have the following restrictions to the use or disclosure of my healthcare information:

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I understand and accept the terms of this consent and acknowledge receipt of the Receipt of Georgia Notice Form.

_____ _____
Client's name (printed) Date

_____ _____
Signature of Client or Legal Guardian Witness Signature