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**Patient Consent for Use and Disclosure
of Protected Health Information (HIPPA Acknowledgement)**

I hereby give my consent for [your company name here] to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by [your company name here] describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent.

D J Koehn Consulting Services Inc. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to [your name and phone number here].

With this consent, D J Koehn Consulting Services Inc. may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including test results, among others.

With this consent, D J Koehn Consulting Services Inc. 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 as long as they are marked "Personal and Confidential."

With this consent D J Koehn Consulting Services Inc. may e-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. I have the right to request that D J Koehn Consulting Services Inc. restrict how it 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.

By signing this form, I am consenting to allow D J Koehn Consulting Services Inc. to use and disclose my PHI to carry out TPO.

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, D J Koehn Consulting Services Inc. may decline to provide treatment to me.

Name of client

Date

Signature of adult client or parent/guardian of client