The Human Aspect LLC

4 Park Plaza Suite 204A Wyomissing, PA 19610 Phone: 484-706-9491 www.humanaspectllc.com

CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

By my signature below, I give my consent to The Human Aspect, LLC to use and disclose, for the purpose of carrying out treatment, payment, an/or health care operations, protected health information in reference to

_____ _____

Client's Name Date of Birth

I have had the opportunity to review the **Notice of Privacy Practices** of The Human Aspect, LLC. I understand that the terms of this Notice may change from time to time, in which case I will be notified of such changes, either verbally or in writing, and, upon my request will be provided the opportunity to review the new Notice.

I understand that I have the right to request that The Human Aspect, LLC restricts the use or disclosure of protected health information for carrying out treatment, payment and/or health care operations. I also understand that The Human Aspect, LLC is not required to agree to any restriction; however, if the requested restrictions are agreed to by The Human Aspect, LLC, those restrictions are binding.

In addition, I understand that The Human Aspect, LLC may make treatment conditional on my signing this Consent. Finally, I understand that I have the right to revoke this Consent, in writing, at any time, except to the extent that The Human Aspect, LLC has acted in reliance hereon.

_____ _____

Client's Signature (if over the age of 14) Date

_____ _____

Parent or Legal Guardian's Signature Date
(for clients younger than 14)

_____

Relationship to Client

Restrictions: _____