Notice of Privacy Practices Acknowledgement and Consent to use and disclose your health information
This form is an agreement between you, ______________________________ and Northwest Neurobehavioral Institute NNI). When I use the word "you" below, it will mean your child, relative, or other person if you have written his or her name here ____.

When your provider at NNI diagnoses, treats, or refers you we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let NNI use your information in this office and send to others. The Notice of Privacy Practices (NPP) explains in more detail your rights and how we can use and share your information. Please read the NPP before you sign this Consent form.

If you do not sign this consent form agreeing to what is in my Notice of Privacy Practices NNI cannot treat you.

In the future we may change how we use and share your information and so may change the Notice of Privacy Practices. If we do change it, you can get a copy from our office.

If you are concerned about some of your information, you have the right to ask your provider to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell you provider what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling your provider you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

Your signature below also acknowledges receipt of the Notice of Privacy Practices.

___________________________________ ______________________________ _______________
Signature of patient (13 years and older) Printed name Date

___________________________________ ______________________________ _______________
Signature of parent/legal guardian/representative Printed name Date

If the Authorization is signed by a personal representative of the patient, a description of such representative's authority to

act for the patient must be provided: ____

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