

Client Consent for Use and Disclosure of Protected Health Information

I hereby acknowledge that I have read and understand the Client Consent for Use and Disclosure of Protected Health Information form. I also have been notified that I have the right to obtain a copy of this information. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Dr. Matoff.

Client name (Printed) _____

Signature: _____ Date _____

Name and Signature of parent or Guardian if client is a minor

Signature: _____ Date _____