



501 Church St. NE Suite 106
Vienna, VA 22180
(703) 755-0995
jenniferspeedlpc@gmail.com

Consent to use and Disclose your Health Information

This form is an agreement between you, _____ and Solution Focused Therapy Services. When we use the word “you” below, it will mean your child, relative, or other person if you have written his or her name here _____.

When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information 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 for other business or government functions.

By signing this form you are agreeing to let us use your information here. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent Form.

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

In the future we may change how we use and share information and so may our Notice of Privacy Practices. If we do not change it, you can get a copy by calling us at (703) 754-0636, or in person from our privacy officer.

If you are concerned about some of your information, you have the right to ask us not to use or share some of your information for treatment, payment, or administrative purposes. You will have to tell us 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 us you no longer consent) and we will comply with your wishes about using and sharing your in-



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Therapy Services, LLC*

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formation from that time on but we may already have used or shared some of your information and cannot change that.

Signature of client or his/her representative _____

Printed Name of Client or Personal Representative _____

I have received a copy of the Notice of Privacy Practices:

Client Initials _____

Date _____

Relationship to Client _____

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