# CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Client Name____________________________ DOB___________ Date _______________

I hereby authorize the clinicians at The Hello Clinic to consult with the following service providers. He/She is permitted to request and/or share information deemed relevant for the coordination of services including test results, treatment plans and clinical impressions.

Medical Providers OK to contact:
Name: ________________________________________________
Title: ________________________________________________
Phone number: ________________________________________
Address:
__________________________________________________________________

Name: ________________________________________________
Title: ________________________________________________
Phone number: ________________________________________
Address:
__________________________________________________________________

Name: ________________________________________________
Title: ________________________________________________
Phone number: ________________________________________
Address:
__________________________________________________________________

I understand the records are protected under the federal and state confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time________(initial)

SIGNATURE: I have read this consent and I understand it.

______________________________________________ ____________________
Signature of Legal Guardian Date

______________________________________________ ____________________
Print Name of Legal Guardian Relationship to Patient