CONSENT to Use and Disclose Protected Health Information
For the Purpose of Coordinating with Insurance Carrier

Date: _____Client Name _____

My initials on each item below represent:

_____1. That I am giving my voluntary consent for my provider Annabel Agee or her associate to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO).for the purpose of coordinating resources with my insurance provider.

_____2. That I have been informed that my consent to use and disclose PHI and to carry out TPO may be rescinded at my discretion.

_____3. That I have been informed that my provider or her associate may need to contact me by phone, regular mail, or email and that if any of my contact information is sensitive I am responsible for letting my provider know which means to use..

My signature below represents I have been informed of my rights and responsibilities as a client had that I have had the opportunity to ask questions and gather information.

Client signature:_____ Date:_____

Witness Signature:_____ Date:_____

Annabel Agee, PhD, LPC/MHSP, NCC TN LPC 2052 NPI 1407946056