CORNERSTONE COUNSELING CENTER
6011 Jonestown Road, Harrisburg, PA 17112
(717) 671-9520 FAX (717) 671-9524

Consent to use and disclose your health information

This form is an agreement between you, _____, and Cornerstone Counseling Center. 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 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 us use your information here and send it to others. 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 your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy by calling us at (717)671-9520, or from our privacy officer.

If you are concerned about some of your information, you have the right to ask us to not 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 or sharing your information 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 or her personal representative Date

_____ _____
Printed name of client or personal representative Relationship to the client

I give my consent for services for myself or my child/legal dependent with

Cornerstone Counseling Center, PC to

include: evaluation, psychotherapy, testing (if indicated) and involvement in the treatment planning and implementation process.

_____ _____
Signature of Patient (or guardian if patient under age 14) Relationship to Patient (if signer is other than patient)

_____ _____
Patient's Date of Birth Signature of Witness

_____ _____
Date Date

Date of NPP 4/14/03 Copy given to the client/parent/personal representative