**MARGO TIRADO MA, LCPC Ltd & Associates**

**5757 S. Madison Street**

**Hinsdale, IL 60521**

**708-288-9021**

**CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, understand that as part of my healthcare, Margo Tirado, MA, LCPC Ltd & Associates originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

* A basis for planning my care of treatment.
* A means of communication among health professionals who contribute to my care.
* A source of information for applying my diagnosis information to my bill.
* A means by which, a third-party payer can verify that services billed were actually provided
* A tool for routine healthcare operations such as assessing quality and reviewing competence of health care professionals.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that

Margo Tirado, MA, LCPC Ltd & Associates reserves the right to change its notice and practices and, prior to implementation, will provide a revised copy to the client. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Margo Tirado, MA, LCPC Ltd & Associates is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance theron.

I wish to have the following restrictions to the use or disclosure of my health information:

I fully understand and accept/decline the terms of this consent.

**(Please circle either accept or decline)**

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Client/Parent Guardian (Circle One) Date

 **MARGO TIRADO MA, LCPC 180-002686 IL**

**ELIZABETH LIM MA, LCPC 180-009007 IL**

**NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

**I have received the attached Margo Tirado, MA, LCPC Ltd & Associates**

**“Notice of Privacy Practices”.**

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Signature of Patient Date

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Print Name Patient’s Date of Birth

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Signature of Parent/Guardian Relationship to Patient

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Witness/Therapist Date