

## CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This form is an agreement between you (please place your name here) \_\_\_\_\_ and Youth Behavioral Health, LLC.

Information collected here as part of your evaluation, treatment and/or referral is legally called Protected Health Information (PHI) about you. This information is used here to determine what treatment is best for you and to provide treatment to you. This information may also be shared 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 allow your Protected Health Information to be used here and to send it to appropriate others as defined by the Notice of Privacy Practices (NPP). The Notice of Privacy Practices explains in more detail your rights and how your information can be used and shared. Please read this before you sign this Consent form.

**If you do not sign this consent form agreeing to what is in the Notice of Privacy Practices, evaluation and treatment cannot take place.**

In the future, should the NPP change, you will be provided with an updated copy of the new NPP.

If you are concerned about some of your information, you have the right to request that the information not be used or shared for treatment, payment or administrative purposes; please make such a request in writing. Though not required, every effort will be made to honor your request. Any exceptions will be clearly discussed.

After signing this consent, you have the right to revoke it by writing a letter stating the consent is withdrawn and your request will be honored. Please be aware, however, that any information already used or shared cannot be changed.

\_\_\_\_\_  
Signature of patient or personal representative

\_\_\_\_\_  
Date