Kathleen Cramer, Ph.D.

Consent for Purpose of Treatment, Payment and Healthcare Operations

I consent to the use and disclosure of _____'s Protected Health Information by KATHLEEN CRAMER, PH.D. (hereinafter "Dr. Cramer")

Print Patient Name Here

for the purpose of diagnosing, providing treatment, obtaining payment for health care bills, or conducting health care operations of Dr. Cramer's practice. I understand that the diagnosis or treatment by Dr. Cramer may be conditioned upon this consent as evidenced by the authorizing signature on this document.

I understand I have the right to request a restriction as to how protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of Dr. Cramer's practice. Dr. Cramer is not required to agree to the restrictions that I request. If she agrees to a restriction, then such restriction is binding on her. I have the right to revoke this consent at any time, in writing, except to the extent that Dr. Cramer has taken action in reliance on this consent.

My "Protected Health Information" means health information (including demographic information) that is collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to past, present, or future physical or mental health conditions and identifying information.

I understand that I have the right to review Dr. Cramer's HIPAA Notice of Privacy Practices (a copy of which has been provided to me) prior to signing this Consent. The HIPAA Notice of Privacy Practices describes various uses and disclosures of protected health information that may occur in (1) the course of my treatment/bill payment or (2) the performance of healthcare operations by Dr. Cramer's office. The HIPAA Notice of Privacy Practices also describes patient's rights and Dr. Cramer's duties with respect to protected health information.

Dr. Cramer reserves the right to change the privacy practices that are described in the HIPAA Notice of Privacy Practices. I may obtain a revised HIPAA Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or by asking for same at the time of my next appointment.

_____
Signature of Patient/Parent/Legal Guardian

_____
Printed Name of Patient/Parent/Legal Guardian

_____
Date