

### **Consent to use and disclose your health information**

By signing this form you are agreeing to allow Mental Health Professionals, Inc. to use the Protected Health Information (PHI) we acquire with regard to you, in the ways outlined in our Notice of Privacy Practices of which you have been provided a copy of. Please review that document and ask any questions you may have before signing this consent.

**If you do not sign this consent form agreeing to the protocol described in our Notice of Privacy Practices we cannot treat you.**

If in the future we change our Notice of Privacy Practices, we will provide our active clients with a copy of our updated or revised form.

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.

\_\_\_\_\_  
Signature of Client or Legal Guardian

\_\_\_\_\_  
Date

Ver. MHP 01-02-05