400 S. Monroe St. San Jose, CA 95128 | Phone: (408) 431-0231 | www.WhiteTulipTherapies.com

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

This form is an agreement between you_____ and White Tulip. When we use the word "you" below, it will mean your child[1], relative, or other person if you have written his or her name here_____.

When we evaluate, diagnose, treat or refer we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information to decide on what treatment is best for you and to provide treatment to you. All information discussed within sessions and contained in the written records pertaining to those sessions ***is confidential*** and may not be revealed to anyone without your written permission, except where disclosure is required by law. We will only share this information with others who provide treatment to you and to others if you have given us specific authorization to do so using a separate document (Authorization to Release and Exchange Information). The Notice of Privacy Practices describes in detail the situations in which we are required or permitted to disclose information by law, your rights, and how we use and share information in our practice. Please read the Notice of Privacy Practices before signing this consent form.

By signing this form you are agreeing to let us use your information here to complete an evaluation, make recommendations for treatment, and provide treatment. If you do not sign this consent form agreeing to what is in the Notice of Privacy Practices we cannot provide an evaluation or 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 make any changes, an updated version will be clearly marked

[1] Note of Legal Custody: If parents are legally separated or divorced or the child is otherwise under custodial care or guardianship you must submit with this consent the documentation giving you the legal right to pursue medical/psychological treatment for the child. In the case of joint custody, both parents will need to initial, sign and date this document. If both signatures are not present on this document we will not be able to see your child.

for viewing in the waiting area. You may also receive an updated copy from us in person or by mail. If you are concerned about some of your information, you have the right to ask us not to use some of your information for evaluation or treatment purposes. You will have to tell us what specific limitations you wish to place, 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 wishes.

After you have signed this consent, you have the right to revoke it by writing a letter telling us you no longer consent, or completing a form to request restrictions on communication and disclosure of your personal health information. We will comply with your wishes about using or sharing information from that time on.

_____ Date: _____
(Printed Name of Client)

_____ Date: _____
(Signature of Client or Personal Representative)

_____ _____
Name of Personal Representative Relationship to Client

DATE OF NPP: April 14, 2003 (Revised 10/01/04)

❑ Copy given to client/parent/personal representative