P: ((202) 991-0766 E: nikkealpc@besimplycandid.com W: besimplycandid.com

Consent for use and Disclosure of Health Information

I, _____, (client) hereby permit and release to Nikkea Jones all medical and financial data related to my care that may be necessary now or in the future for purposes of treatment, payment or healthcare operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to HMOs, PPOs, managed care organizations, IPAs, or other governmental or third party payors, or any organization contracting with any of the above entities to perform such functions.

_____ _____

Client or Parent/Guardian Signature Date

You have the right to request restrictions of uses and disclosures of your health information; however, this office is not required to agree to a requested restriction. You have the right to revoke this consent in writing, except to the extent that this office has previously taken action in reliance on this consent. Your treatment by this office is conditional on your signing this consent.

_____ Initial Here