THE MAURIELLO GROUP

BEHAVIORAL HEALTHCARE | CONSULTATIVE SERVICES | IN-SERVICE TRAININGS

CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This form is an agreement between you, and *Matthew J. Mauriello, MA, P.C.* (DBA "The Mauriello Group"). When we use the words "you" and "your" below, this can mean you, your child, a relative, or some other person if you have written his or her name below as the identified client.

When *Matthew J. Mauriello, MA, P.C.* and its staff examine, test, diagnose, treat, and/or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read, heard, and/or received our Notice of Privacy Practices (NPP), which explains in more detail what your rights are and how we can use and share your information.

If you do not sign this form agreeing to our privacy practices, we cannot treat you. As a client of *Matthew J. Mauriello, MA, P.C.*, you are entitled to review and/or obtain a copy of our current NPP. In the future, we may change how we use and share your information, and so we may change our notice of privacy practices. You can review or obtain the most recent copy of the NPP by contacting our privacy officer, Mr. Matthew J. Mauriello. You can also obtain a copy of the NPP by visiting our office location or visiting our website.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked. After you have signed this consent, you have the right to revoke it by writing to our privacy officer. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

______________________________	______________________________	______________
Printed name of client	Signature of client (if age 14 or older)	Date
______________________________	______________________________	______________
Printed name of personal representative	Personal Representative Signature (client under 18)	Date
______________________________	______________________________	______________
Printed name of personal representative	Personal Representative Signature (client under 18)	Date
______________________________	______________________________	______________
Printed Name of Healthcare Provider	Signature of Healthcare Provider	Date

Date of NPP: ____________________________ ❑ Copy given to the client/parent/personal representative