Alexey Tolchinsky, Psy.D.
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Consent To Use and Disclose Your Health Information

This form is an agreement between you, _____ and me, Alexey Tolchinsky, Psy. D. When I use the word "you" below, it will mean your child, relative, or other person if you have written his/her name here: _____

When I examine, diagnose, treat, or refer you, I will be collecting what the law calls Protected Health Information (PHI) about you. I need to use this information to decide on what treatment is best for you and to provide treatment for you. I may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

If you are concerned about some of your information, you have the right to ask me to withhold sharing some of your information for treatment, payment, or administrative purposes. You will have to make your request in writing. Although I will try to respect your wishes, I am not required to agree to these limitations. However, if I do agree, I will comply with your request.

After you have signed this consent, you have the right to revoke it (in writing), and I will comply with your request about using or sharing your information from that time on. However, I may have already used or shared some of your information and cannot change that.

(Please sign and return to Dr. Tolchinsky. Thank you.)

Signature of patient or his/her personal representative _____Date: _____

Printed name of patient or personal representative _____

Relationship to patient: (please circle) Self Spouse Child Parent Other: _____

Description of personal representative's authority: _____