CONSENT FORM TO PROVIDE SERVICES

I need to be sure I have your consent for services. Please read the following carefully.

Consent for Services ☐ Yes, I consent ☐ No, I do not consent

By signing below, I am agreeing to participate in individual psychotherapy with Liz Cohen.

This authorization complies with HIPAA Privacy Rules. I hereby consent to the use and disclosure of my Protected Health Information by the clinicians in order to facilitate the group. I understand that Protected Health Information may include health information which is individually identifiable. I have received a copy of the HIPAA Privacy Practices and have had the opportunity to ask questions about related confidentiality practices.

Informal Consent

I have been made aware of the potential risks as well as the potential benefits of participating psychotherapy. I have had the opportunity t o ask questions and to have my concerns addressed.

Conditions of Authorization for All Consents

I understand that I may revoke any or all authorizations provided herein in writing at any time. Revocation will become effective on the date of notification and will not apply to information that has already been released or obtained in response to this authorization. The consent, unless revoked sooner, will expire one year from the date below.

I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by Federal privacy laws or regulations.

My signature affirms that I have read the above policies and have offered a copy of these authorizations.

Client Printed Name

Client Signature Date

Clinician's Signature Date