Patient Consent for Use and Disclosure Of Protected Health Information

I hereby give my consent for **Marty Tallakson** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Marty Tallakson** reserves the right to revise his Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Marty Tallakson at:

Clarity Counseling
3220 18th Street S Suite 1
Fargo, ND 58104

With this consent, **Marty Tallakson** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **Marty Tallakson** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential." I have the right to request that **Marty Tallakson** restrict how he uses requested restrictions, but if he does, he is bound by this agreement.

By signing this form, I am consenting to allow **Marty Tallakson** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Marty Tallakson** may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date

_____
Print Name of Patient or Legal Guardian, if applicable