



Consent To Use And Disclose Your Health Information

This form is an agreement between you, _____ and *Knoxville Psychiatric Group*. When we use the word "you" below, it will also mean your child, relative, or other person if you have written his/her name here:

When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information to decide what treatment is best for you and to provide treatment to you. We 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, as explained in our Notice of Privacy Practices.

By signing this form you are agreeing to let us use your information here and send it to others. [The Notice of Privacy Practices](#) explains in more detail your rights and how we can use and share your information. Please be sure you have read it before you sign this Consent form.

If you do not sign this consent form agreeing to what is in our [Notice of Privacy Practices](#) we cannot treat you.

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you may obtain a copy from the office at your next visit, or by calling us at (865) 584-8501, or from our privacy officer.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment, or administrative purposes. You will need to inform us in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wishes.

After you have signed the consent, you have the right to revoke it (in writing) and we will comply with your wishes about using or sharing your information from that date forward.

_____ Date: _____
Signature of patient (or parent/legal guardian)

Printed name of patient (or parent/legal guardian)

Relationship to patient: _____

Date of NPP _____ Chart Copy _____ Patient/Parent Copy _____