CYNDIE FORD PURDY, L.M.H.C.
Licensed Mental Health Counselor
National Certified Counselor - Master Addictions Counselor
Substance Abuse Professional
FL License #MH 5401 – NPI #1528115599
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CLIENT CONSENT FORM

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Federal Confidentiality Law (42 C.F.R. Part 2) I have certain rights regarding my protected health information. I understand that, as appropriate, this information can and will be used to:

- ✓ Conduct, plan, and direct my treatment and follow-up
- ✓ Obtain payment from third-party payers
- ✓ Consult with other therapists, physicians, or health care providers who are involved in my treatment

Cyndie Ford Purdy, LMHC has informed me of her privacy practices by providing me with a copy of her Notice of Clinician's Policies and Practices to Protect the Privacy of Client's Health Information, which contains a complete description of the uses and disclosures of my health information. I have been given the opportunity to review my copy of the Notice of Clinician's Policies and Practices to Protect the Privacy of Client's Health Information and to ask any questions about it prior to signing this consent. I understand that this practice has the right to change the Notice periodically and that I may contact this practice at any time, at the address above, to obtain a current copy of the Notice of Clinician's Policies and Practices to Protect the Privacy of Client's Health Information.

I understand that I may request in writing that this practice restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand this practice is not required to agree to my requested restrictions, but if this practice does agree, then it is bound to abide by such restrictions to the greatest extent allowed by law.

I understand that I may revoke this consent at any time, except to the extent that this practice has already taken action in reliance on it.

Client's Signature:________________________________ Date:____________________

Client's Printed Name:____

Signature of Parent or Guardian:_____________________ Date:____________________

If you would like to give permission for this practice to release information to others, please indicate to whom and their relationship to you:

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Please note: You may be asked to complete an Authorization to Release Confidential Healthcare Information for the individuals listed above.