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Larissa Lempert, MD

Diplomate of the American Board of Psychiatry and Neurology

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

I hereby consent to the use or disclosure of my identifiable health information ("protected health information") by Dr. Larissa Lempert, MD in order to carry out treatment, payment, or health care operations. I have been given the opportunity to review Dr. Larissa Lempert, MD Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information. I have the right to review such Notice prior to signing this consent form.

Dr. Larissa Lempert, MD reserves for itself the right to change the terms of its Notice of Privacy Practices for Protected Health Information at any time. If Dr. Larissa Lempert, MD does changes the terms of its Notice of Privacy Practices, you may obtain a copy of the revised Notice by requesting the Notice from the receptionist.

I retain the right to request that Dr. Larissa Lempert, MD further restrict how my protected health information is used or disclosed to carry out treatment, payment, or health care operations. Dr. Larissa Lempert, MD is not required to agree to such requested restrictions; however, if Dr. Larissa Lempert, MD does agree to my requested restriction(s), such restriction(s) are then binding on Dr. Larissa Lempert, MD

At all times, I retain the right to revoke this Consent. Such revocation must be submitted to the Dr. Larissa Lempert, MD in writing. The revocation shall be effective *except* to the extent that the Dr. Larissa Lempert, MD has already taken action in reliance on the Consent. *Dr. Larissa Lempert, MD may refuse to treat you if you do not sign this Consent Form* (except to the extent that Dr. Larissa Lempert, MD is required by law to treat individuals). If you (or authorized representative) sign this Consent Form and then revoke consent, then Dr. Larissa Lempert, MD has the right to refuse to provide further treatment to you as of the time of revocation (except to the extent that the Facility is required by law to treat individuals).

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT, OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS SEALED DOCUMENT VERIFYING CONCENTER TO THE ABOVE STATED TERMS.

_____ _____

Signature of Patient Date

_____

Please Print Name