Consent of Use of Mental Health Information

Person Giving Consent: _____
Address: _____
Telephone: _____
Email: _____
Social Security #: _____

By signing this form, you will consent to the use and disclosure of your protected mental health information to carry our treatment and payment activities.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. You may obtain a copy of the Notice of Privacy Practices, including any revision of the Notice, at any time by contacting:

Margaret Otto
3100 NE 83rd Street, Suite #2350
Kansas City, Missouri 64119
816-436-1721
motto@kcfamilysystems.org

Right to revoke: You have the right to revoke this consent at any time by giving written notice of your revocation submitted to the contact person listed above.

Consent: ____Yes ____No
Revoke Consent: ____Yes ____No
I, _____ have had the full opportunity to read and consider the contents of the Consent form and your Notice of Privacy Practices. That, by signing this consent form, I am giving my consent to your use and disclosure of my protected mental health information to carry out treatment and payment activities.
Client Signature_____Date_____

Signature of parent, Guardian or Personal Representative_____

- If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc)