Life Skills Institute & Clinic
Margaret Green, Ed.D., L.P.
3937 Orchid Lane N
Plymouth, MN 55446

RE: Consent to use and disclose your health information

Dear Patient,

This form is an agreement between you, ___________________________ and me. When we use the word "you" below, it can mean you, your child, a relative, or other person if you have written his or her name here ______________________________.

When we examine, test, diagnose, treat, or refer you I will be collecting what the law calls Protected Healthcare Information (PHI) about you. I need to use this information here to decide on what treatment is best for you and to provide any treatment to you. I 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.

By signing this form you are agreeing to let me use your information here and send it to others. The Notice of Privacy Practices explains in more detail your rights and how I can use and share your information. Please read this 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 I may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy from my office or by calling me at 763-476-1031.

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 have to tell us what you want 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 do as you asked.

After you have signed this consent, you have the right to revoke it (by writing a letter to me telling me you no longer consent) and I will comply with your wishes about using or sharing your information from that time on but we may already have used or share some of your information and cannot change that.

____ _____________
Signature of client of his or her personal representative **Date**

____ _____________
Printed name of client or personal representative **Relationship to client**

____
Description of personal representative's authority

____
Signature of authorized representative of this office or practice

Date of NNP: 4/11/2003