DR. LAUREN GERBER

CONSENT FOR RELEASE AND USE OF CONFIDENTIAL INFORMATION AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, hereby give my
Patient or Guardian
consent to Dr. Lauren Gerber to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of _____.
Patient

I, _____, hereby acknowledge
Patient or Guardian
receipt of Dr. Lauren Gerber's Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand that Dr. Gerber reserves the right to change her privacy practices that are described in the Notice. I also understand that a copy of any revised notice will be provided to me or made available at my request.

I understand that this Consent is valid until it is revoked by me.
I understand that I may revoke this consent at any time by giving written notice or my desire to do so, to Dr. Gerber. I also understand that I will not be able to revoke this consent in cases where the Psychologist has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the Psychologist's office.

Patient Signature
and/or Guardian: _____

Date: _____