Diane Abdo, Psy.D., PA

REQUEST/CONSENT FOR EVALUATION/ TREATMENT FOR PSYCHOLOGY SERVICES

Patient Name _____ Date _____

I voluntarily request the professional services of Diane Abdo, Psy.D. I have been made aware of the risks and potential benefits of psychological services.

I further approve contact with my primary physician, or family members, and appropriate care giver staff, or their designated agents for medical or claims management purposes. As a condition of providing treatment to you, the provider herein requests your consent to use and disclose protected health information about you to carry out treatment, payment, and health care operations.

I hereby consent to the use and disclosure by my provider, its workforce, and its business associates of my protected health information for purposes of treatment, payment, and health care operations.

I understand and agree that my disclosures and communications are considered privileged and confidential except to the extent that I authorize a release of information or under certain other conditions as prescribed by law. I understand that confidential and privileged information may be released without my consent or authorization under circumstances recognized by Florida law and HIPPA.

I hold the above referenced psychologist and their agents, employers, employees, and billing agents harmless against any and all claims arising from the release of Protected Health Information as permitted by law.
I understand that I have a right to revoke this authorization by providing written notice to the administrative offices of **Diane Abdo, Psy.D. P.A. at 5124 Columbo Court, Delray Beach, FL 33484** except to the extent information has been released in reliance upon this authorization prior to receiving my written notice.

Please refer to the Notice of Privacy Practices for Protected Health Information ("Privacy Notice") for a more complete description of the uses and disclosures that the provider may use of your protected health information. You have the right to review the Privacy Notice prior to signing this consent

Signature _____ Printed Name _____ Date _____

Signature _____ Printed Name/Relation to patient _____ Date _____

☐ Patient gave verbal consent/ unable to sign

☐ Patient assisted in giving signature

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