NEW BEGINNINGS
Mental Health and Wellness

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATION INFORMATION

I, the patient, authorize New Beginnings Mental Health and Wellness to use or disclose my protected health information for the purpose of treatment, payment, or healthcare operations as the terms are defined under federal HIPAA privacy rules.

• I have the right to revoke this consent; such revocation must be submitted to New Beginnings Mental Health and Wellness in writing. The revocation shall be effective except to the extent that New Beginnings Mental Health and Wellness has already taken action in reliance on the consent.

• I have received a copy of New Beginnings Mental Health and Wellness "Notice of Privacy Practices" as required by HIPAA.

• I understand, acknowledge, and agree to the information above.

If you would like for New Beginnings Mental Health and Wellness to disclose your health information (medical condition, diagnosis, treatment, payment, healthcare options) to anyone, please list their names, numbers, and relationship to you below:

Name	Number	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____ _____

Printed Patient Name Date Signature of Patient

*If signing as a legal guardian, you are verifying that you are giving consent to the above listed conditions for your minor child.