

Laura Dahmer-White, Ph.D.
Clinical Neuropsychologist
2620 RW Johnson Rd. SW, St. 204
Tumwater, WA 98512
Ph.: 360 709-0601 Fax: 360 528-2080

HIPAA Consent to Use and Disclose Your Health Information

This form is an agreement between you and Laura Dahmer-White, Ph.D. When we use the word “you” below, it will mean you and any person whose name you have written here _____ (as a person with whom we may share your healthcare information).

When we examine, diagnose, treat or refer you, we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this to decide on what treatment is best for you and to provide treatment. We may also share this information with others who provide treatment to you or need to arrange payment for treatment or for other business or government functions.

By signing this form you are agreeing to let us use your information here and to send it to others. The Notice of Privacy Practices (NPP) explains more in detail your rights and how we can use and share information. Please read this before you sign this Consent form.

If you choose not to sign this Consent form, agreeing to what is in our Notice of Privacy Practices, we can not treat you.

In the future, we 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 by calling us at 360-709-0601.

If you are concerned about some of your information, you have the right to ask us not to use or share some of. You will need to tell us in writing what you want. 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 comply with them.

After you have signed this Consent, you have the right to revoke it (in writing) and we will comply with your wishes from that time on, but we can not change what we may have already used or shared

Signature of client

Printed Name

Date