Cognitive Health Solutions LLC

Main Office (Hanover):
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York Office:
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York, PA 17402
Phone: (717) 747-3659
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Chambersburg Office:
550 Cleveland Avenue, Suite 101
Chambersburg, PA 17201
Phone: (717) 446-0232
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Consent Regarding Notice of Privacy Practices for Protected Health Information

I understand that I have certain rights to privacy regarding my *Protected Health Information (PHI).* These rights are given to me under the Health Insurance Portability and Accountability Act of 1996. I consent to the use or disclosure of my/my child's PHI by *Cognitive Health Solutions, LLC* (CHS), for the purposes of (1) diagnosing and/or providing treatment to me/my minor child; (2) obtaining payment for my/my minor child's health care bills; and/or (3) to conduct routine health care at their office.

If, based on professional judgment, it is suspected that a child has been abused we are required to report suspicions to the authority or government agency vested to conduct child-abuse investigations. We are required to make such a report even if we do not see the child in a professional capacity. We are mandated to report suspected child abuse if anyone aged 14 or older tells us that they committed child abuse, even if the victim is no longer in danger. We are also mandated to report suspected abuse if anyone discloses that he or she knows of any child currently being abused.

I understand that I have a right to review the *Notice of Privacy Practices (NPP)* which contains a more complete description of the uses and disclosures of my PHI and my rights under HIPAA. I acknowledge that CHS reserves the right to change the privacy practices described in the *NPP,* and I may obtain a revised *NPP* by calling the office and requesting that a revised copy be sent in the mail and/or asking for a copy at the time of my or my child's next appointment. I understand that after signing this consent form I may revoke it in writing at any time, but any previously shared information cannot be retrieved.

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Please read this before you sign this Consent form. If you do not sign this consent form agreeing to our NPP, we cannot complete an evaluation or provide any psychological services to you or your child.

A COPY OF THE NOTICE OF PRIVACY PRACTICES FOR COGNITIVE HEALTH SOLUTIONS, LLC IS AVAILABLE IN THE WAITING ROOM AREA.

Patient Name (print)	**Patient Signature (if 18+)**	**Date**

***If joint legal custody exists, both parents/guardians must sign**

Mother/Legal Guardian Name (print)	**Mother/Legal Guardian Signature**	**Date**

Father/Legal Guardian Name (print)	**Father/Legal Guardian Signature**	**Date**