PEGGY KRUGER
TIETZ PH.D.
LICENSED PSYCHOLOGIST

CONSENT TO THE USE AND DISCLOSURE OF THE HEALTH INFORMATION

FOR TREATMENT, PAYMENT, AND OPERATION

I understand that as part of my healthcare, Peggy Kruger Tietz, Ph.D., originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

1. A basis for planning my care and treatment.
2. A means for communication among health professionals who contribute to my care.
3. A source of information for applying my diagnosis information to my bill.
4. A means by which a third-party payer can verify that services billed were provided.
5. A tool for routine operations such as assessing quality of care.

I understand and have been provided with a HIPAA Notice of Privacy that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Peggy Kruger Tietz, Ph.D. reserves the right to change her notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that my health information will not be used for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment or payment. I understand that I may revoke this consent in writing, except to the extent that Peggy Kruger Tietz, Ph.D. has already taken action in reliance theron.

Signature:

_____ _____

Patient/ Legal Guardian Date

1301 S. Capital of Texas Hwy, Bldg. C, Suite 130, Austin, TX 78746