# Karyn L. Aho, Ph. D.

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## ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I understand that Karyn L Aho Ph.D. will use and disclose health information about me. I understand that my health information may include information both created and received by Karyn L Aho Ph.D.., may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that Karyn L. Aho Ph.D. may use and disclose my health information in order to:

1. Make decisions about and plan for my care and treatment
2. Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment
3. Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all my health care
4. Perform various office, administrative and business functions that support my provider's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care

I also understand that I have the right to receive and review a written description of how Karyn L Aho Ph.D. will handle health information about me. This written description is known as a Notice of Privacy Practices. It describes the uses, disclosures of and my rights, regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of my provider (Karyn L Aho Ph.D.) will be posted to her website and in her waiting room area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that my provider (Karyn L Aho Ph.D.) is not required by law to agree to such requests.

After you have signed this consent, you have the right to revoke it by writing to our compliance officer. We will then stop using or sharing your PHI, but if we have already used or shared some of it, and we cannot change that.

I consent to have my medical records shared with my physician (check box)

I consent to have my medical records shared with my referral source (check box)

Click here to receive a copy of our Notice of Privacy Practices: Brief Version - Full Version

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

_____

Client Full Name

_____ _____

Client Signature Date

The effective date of this notice is 03/30/2020