



# COUNSELING AND DIAGNOSTIC CENTERS, LLC

## Consent to use and disclose your health information

A. Dewey Sanders, Ph.D.  
*Counseling Psychologist*

This form is an agreement between you, \_\_\_\_\_ and CDC. When we use the word “you” below, it will mean your child, relative, or other person if you have written his or her name here \_\_\_\_\_.

Thomas W. McCann, M.S., Ed.D.  
*Certified Clinical Psychologist  
With Autonomous Functioning*

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 information here to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

Thomas C. Noyes, Ph.D.  
*Licensed Clinical Psychologist*

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

Donald May, LCSW  
*Licensed Clinical Social Worker*

Teresa Garera Izquierdo, Psy.D.  
*Licensed Clinical Psychologist*

### **If you do not sign this consent form agreeing to what is in our Notice of Privacy Practice we cannot treat you.**

Cary N. Wallis, Psy.D.  
*Licensed Clinical Psychologist*

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 from our office, or by calling us at 859-282-0119, or from our privacy officer.

Terry L. Hirschfeld, LCSW  
*Licensed Clinical Social Worker*

Matt McCann, Psy.D.  
*Licensed Psychologist*

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not requiring to agree to these limitations. However, if we do agree, we promise to comply with your wish.

7315 Dixie Highway  
Florence, KY 41042  
Ph: (859) 282-0119  
Fax: (859) 282-8018

After you have signed this consent, you have the rights to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

26 Audubon Place  
Ft. Thomas, KY 41075  
Ph: (859) 781-5719  
Fax: (859) 781-7169

\_\_\_\_\_  
Signature of client or his or her personal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of client or personal representative

\_\_\_\_\_  
Relationship to the client

\_\_\_\_\_  
Description of personal representative’s authority

E-mail: CDC26@fuse.net

Date of NPP \_\_\_\_\_

Copy give to the client/ Parent/ Personal representative.