

# Burke Behavioral Health, LLC

Director: Philip Burke, PhD, Licensed Clinical Psychologist

West County Medical Center  
19 East Shawnee Drive  
Murphysboro, IL 62966  
(618) 684-8700

## Consent to use and disclose your health information

This form is an agreement between you, \_\_\_\_\_, and Burke Behavioral Health, LLC. When we use the word "you" below, it can mean you, your child, a relative, or other person(s) if you have written his or her name(s) here: \_\_\_\_\_.

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

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

**If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot 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 from our Web Site, [www.burkepsych.com](http://www.burkepsych.com) or by calling us at (618) 684-8700 or (618) 549-9000.

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 required to agree to these limitations. However, if we do agree, we promise to do as you asked.

After you have signed this consent, you have the right to revoke it (by writing a letter to our Privacy Officer 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.

\_\_\_\_\_  
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

\_\_\_\_\_  
Signature of authorized representative of this office or practice

Date of NPP: February 2008    \_\_\_ Copy give to the client/parent/personal representative.

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