Sarah A. Hover, Ph.D., PLLC
Licensed Clinical Psychologist
Suite 303
380 Maple Avenue, West
Vienna, VA 22180
703-938-5234 ext 5

Consent to HIPAA Conditions

I have read the HIPAA Notice, including privacy and my rights regarding my/my child's Personal Health Information (PHI) and Psychotherapy Notes.

I consent to the use and disclosure of my PHI /Psychotherapy Notes for purposes of treatment, payment, or other health care operations. I understand and agree to the legally imposed required disclosures and the stated office practices, which do not require my signature for disclosure.

Other uses of my PHI/Psychotherapy Notes will require an authorization from me for the specific intention of the disclosure.

_____on behalf of_____
Signature of Guardian Child

Printed Name: _____

Date: _____

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Consent to limitations on confidentiality

I have read the Confidentiality Practices as put forth on page 3 of the Office Practices at www.hoverpsych.com. I understand the limitations that may be imposed on confidentiality as I (or my child) receive mental health services from Sarah A. Hover, Ph.D. I hereby accept those limitations of confidentiality and consent to receive services under those conditions.

CLIENT NAME: _____ DATE OF BIRTH: _____

If the Client is under age 18, both parents' signatures are required:

Mother: _____ Date: _____

Father: _____ Date: _____

Client Signature if over 18: _____ Date: _____