

**Glenn E. Cahn, Ph.D. PLLC**  
**3205 Randall Parkway, #117**  
**Wilmington, NC 28403**

Consent to Use and Disclose Health Information

This form is an agreement between \_\_\_\_\_ (please print your name) and Dr. Glenn Cahn. When the word 'you' is used below, it will mean your child, relative, or other person if you have written that individual's name here \_\_\_\_\_.

When you are examined, diagnosed or treated, data is obtained that the law calls Protected Health Information (PHI). Dr. Cahn needs to use this information here to decide on what treatment is best for you and to provide it as needed. He may also share this information with others who provide treatment to you, or may need it to arrange payment for your treatment or for other business or government functions.

By signing this form, you are agreeing to let him use your information here and send it to others as needed. The Notice of Privacy Practices explains in more detail your rights and how he can use and share your information. Please read this other form before you sign this Consent form.

**If you do not sign this consent form agreeing to what is in the Notice of Privacy Practices, Dr. Cahn can not treat you.**

In the future, he may change how he uses and shares your information and so may change the Notice of Privacy Practices. If he does change it, you can get a copy by contacting him.

If you are concerned about some of your information, you have the right to ask him to not use or share it for treatment, payment or administrative purposes. You will have to tell Dr. Cahn what you want kept private in writing. Although he will try to respect your wishes, he is not required to agree to these limitations. However, if he does agree, he promises to comply with your wish.

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

This consent form expires on \_\_\_\_\_. Unless I sign a new form, no more of this information can be used or released.

I also understand that if the person or organization that receives my information is not a health care provider or health insurer, the information may no longer be protected by federal privacy laws, and can then be shared with others without my consent.

\_\_\_\_\_  
Signature of client or legal representative

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Relationship

[ ] NPP copy given to the client/parent/representative