Telephone Number: (323) 388-9982
Fax Number (323) 592-3779
Email: info@hiddentreasuresaba.com

Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices

I,_____, hereby give my consent to ABA Behavioral Therapy Services, LLC,
(Name of Patient or Authorized Agent)
dba, Hidden Treasures, to use or disclose, for the purpose of carrying out treatment, payment or health care operations, all information contained in the patient record of:

_____
(Patient's Name)

I acknowledge receipt of the Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand that all payments of authorized benefits for services provided to me from the company will be made to the company.

I understand that the company has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available to me upon request.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the company. I also understand that I will not be able to revoke this consent in cases where the company has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the company's office.

Signed: _____ Date:_____

If you are not the patient, please specify your relationship to the patient: _____