Bloomfield Consulting, PLLC
300 E. Long Lake Rd., Suite 130, Bloomfield Hills, MI 48304 / 248.792.2101 Phone 248.792.2401 Fax

Consent to Use or Disclose Protected Health Information

By signing this form, I consent to the use or disclosure of my Protected Health Information by my provider, Bloomfield Consulting, PLLC / Dr. Laura Fadell, to my insurance provider for the purpose of billing for services.

Protected Health Information means health information (including identifying information about me) collected from me by Dr. Fadell. It may include information about my past, present, or future physical or mental health or condition, the provision of my health care, and payment for my health services.

Bloomfield Consulting, PLLC / Dr. Fadell agrees to maintain my Protected Health Information in accordance with the practices described in the Privacy Notice. This notice also describes my rights with respect to the use and disclosure of my Protected Health Information.

I acknowledge that I have been given a copy or the Privacy Notice and/or I have been given an opportunity to review the Privacy Notice prior to signing this consent. The Privacy Notice is also posted on Dr. Fadell's website (www.drfadell.com), in clear view for patients to read.

I understand that this information may be needed to:

- Plan my care and treatment
- Communicate among the various health care professionals involved in my care
- Provide information to my health insurance company or plan for billing purposes
- Obtain payment from my health insurance company or plan
- Assess the quality of my care and review the care provided by BCG staff

I also understand that I have the right to revoke the Consent, in writing, at any time, except to the extent that BCG has taken action in reliance upon this consent.

I further understand I have the right to request a restriction as to how my Protected Health Information is used/disclosed to carry out treatment, payment, or health care operations of Bloomfield Consulting, PLLC / Dr. Fadell. I realize that Dr. Fadell is not required to agree to a restriction that I may request. However, if Dr. Fadell does agree, the restriction must and will be honored by Bloomfield Consulting, PLLC / Dr. Fadell.

Restrictions:_____

_____

(Signature of Patient/Guardian) (Relationship to Patient) (Date)

_____

(Signature of Witness/Staff) (Date)

Withdrawal of Consent: This consent is revoked on:_____

(Date)

_____

(Signature of Patient/Guardian) (Date) (Signature of Witness/Staff) (Date)