Janet D. Byars, MS, LCMFT
Marriage & Family Life Clinic______________________________
913-707-848 8100 Marty, Ste 107 janetbyarstherapy@gmail.co,
Overland Park, KS 66204 www.kcmarriageandfamilylifeclinic.com

HIPAA CONSENT FORM

I give **Janet D. Byars, MS, LCMFT** my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for healthcare operations like quality reviews.

I have been informed that I may review the HIPAA Notice of Privacy Practices used by **Janet D. Byars, MS, LCMFT** for a more complete description of uses and disclosures before signing this consent.

I understand that I have the right to request a restriction of how my protected health information is used, However, I also understand that **Janet D. Byars,MS, LCMFT,** Kansas City Marriage & Family Life Clinic, is not required to agree to the request. If **Janet D.Byars, MS, LCMFT** agrees to my requested restriction, they must follow the restrictions.

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

______________________________ __________
Signature Date

______________________________ __________
Signature Date

If signed by patient representative, state relationship to patient: __________________