Kay E. Uhl, MA

LICENSED MENTAL HEALTH COUNSELOR

License #LH00004384

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

I understand that, consistent with the HIPAA requirements, consent to treatment and consent to release will expire after twelve months and I may revoke such consent at will although revocation is to retroactive. I have been informed of and read the preceding information and agree to it. I authorize treatment of the person named below and agree to pay all fees for services rendered by my therapists. If you have any questions or would like additional information, please feel free to ask.

ATTESTING THAT I UNDERSTAND THE ABOVE AND AGREE TO THERAPY UNDER THE ABOVE LIST OF DISCLOSURES I HAVE SIGNED BELOW.

Client

Signature _____Date_____

Spouse/Partner/Family/Marital Counseling

Signature _____Date_____

Therapist

Signature _____Date_____