
CHRISTOPHER H. ANDERSON, LCSW
PSYCHOTHERAPIST / CLINICAL SOCIAL WORKER

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Consent and Acknowledgment Form

I consent to the use or disclosure of my protected health information by Christopher H. Anderson, LCSW to any person or organization for the purpose of carrying out treatment, obtaining payment, or conducting certain healthcare operations. Protected health information used or disclosed by Christopher H. Anderson, LCSW may include HIV/AIDS related information, psychiatric and other mental health information, and drug and alcohol treatment information, as long as such information is used or disclosed in accordance with Connecticut and Federal law, which may require that I provide specific authorization. I understand that information regarding how Christopher H. Anderson, LCSW will use and disclose my information can be found in the Notice of Privacy Practices. I understand that this consent is effective for as long as Christopher H. Anderson, LCSW maintains my protected health information.

By signing below, I understand that acknowledge to following:

- I have read and understand the consent; and
- I have received Christopher H. Anderson, LCSW's Notice of Privacy Practices currently in effect.

Print Name of Individual 1

Signature of Individual 1

Date

Print Name of Individual 2

Signature of Individual 2

Date

Unable to obtain written consent and acknowledgment because:

___ Individual refused

___ Emergency Treatment Situation

___ Individual not able to sign due to incompetence or other medical reason

___ Other: _____