

**Traci L. Wallace, Ph.D.**  
*Licensed Psychologist*  
*PSY 14644*

**Consent to Use or Disclose Information for  
Treatment, Payment, and Health Care Operations (TPO)**

Patient Name: \_\_\_\_\_  
(please print)

Federal regulations (HIPAA) allow me to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for the services I provide, and for other professional activities (known as “health care operations”). Nevertheless, I ask your consent in order to make this permission explicit. The Notice of Privacy Practices describes these disclosures in more detail. You have the right to review the Notice of Privacy Practices before signing this consent. I reserve the right to revise my Notice of Privacy Practices at any time. If I do so, the revised Notice will be posted in the folder in the waiting room. You may ask for a printed copy of the Notice at any time.

You may ask me to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or health care operations; however, I do not have to agree to these restrictions. If I do agree to a restriction, that agreement is binding.

You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation.

This consent is voluntary; you may refuse to sign it. However, I am permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked.

I hereby consent to the use or disclosure of my Protected Health Information as specified above.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

*3101 Ocean Park Boulevard, Suite 311 Santa Monica, California 90405*

*310-425-5175*