RECEIPT OF FLORIDA NOTICE FORM

By signing below, I am acknowledging that I have read and/or received a copy of the Florida Notice Form and I am in agreement with the terms and conditions of treatment, release of information and payment for services rendered by practitioner Matt Fahy L.M.H.C.

This notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature and date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. Matt Fahy L.M.H.C. is not required to agree with this restriction, but if does, shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Ave of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to the use and disclosure of your protected healthcare information and potentially anonymous usage in publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice of Matt Fahy L.M.H.C. reserves the right to change the privacy policy as allowed by law.
- The practice of Matt Fahy L.M.H.C. has the right to restrict the use of the information but the practice of Matt Fahy L.M.H.C. does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice of Matt Fahy L.M.H.C. may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed: ______________________________

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This consent was signed by (print name): ______________________________

____

Signature and Date

Matt Fahy, L.M.H.C.
License No. MH14433

www.MattFahy.com
727-386-9549