



## Clear Horizons Clinical Services

1220 North Main St Ste 10

Springville, Utah 84663

(801) 358-4463

### Notice Of Privacy Policies

For records regarding:

\_\_\_\_\_  
Client Name

\_\_\_\_\_  
Client Number

\_\_\_\_\_  
Date

This form is an agreement between you, and me/us, When we use the words "you" and "your" below, this can mean you, your child, a relative, or some other person if you have written his or her name here:

When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

**If you do not sign this form agreeing to our privacy practices, we cannot treat you.** In the future, we may change how we use and share your information, and so we may change our notice of privacy practices. If we do change it by calling us at 801-358-4463.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing.

Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked. After you have signed this consent, you have the right to revoke it by writing to our privacy officer. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

\_\_\_\_\_  
Signature of Client or his/her Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Client or Personal Representative

\_\_\_\_\_  
Description of Representative's authority

\_\_\_\_\_  
Signature of Authorized Staff

\_\_\_\_\_  
Date

Date of NPP: \_\_\_\_\_

☐ Copy given to the client or personal representative