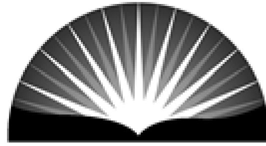
Michael S. Trieger, Psy.D.
Licensed Clinical Psychologist

Melissa Fisher Paoni, Ph.D.
Licensed Clinical Psychologist

Lori K. McKenzie, Psy.D.
Licensed Clinical Psychologist

Bill McKenzie, MA, LCPC
Licensed Clinical Professional Counselor



Springfield Psychological Center, LLC

Greg Irwin, LCPC
Licensed Clinical Professional Counselor

Jeanette Hoelzer, LCPC
Licensed Clinical Professional Counselor

Bethany Bilyeu, Psy.D.
Licensed Clinical Professional Counselor

Kelsie Tobias, LCSW
Licensed Clinical Social Worker

CONSENT TO USE AND DISCLOSE YOUR MENTAL HEALTH INFORMATION

This form is an agreement between you and your mental health professional at The Springfield Psychological Center. When we use the word "you" it will mean your child, relative, or other person if you have written his/her name here (**patient's name**): ____.

When we examine, diagnose, treat, or refer you, we will be collecting private mental health information about you. We need to use this information here to decide what treatment is best for you and to provide the treatment to you. We may share this information with others, when permitted by law, who provide treatment to you. We may also share this information to arrange payment for your treatment or for business or for other government functions.

By signing this form, you are agreeing to let us use your information here. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read the Notice of Privacy Practices before signing this consent form.

If you do not sign this consent form agreeing to what is in our Privacy Practices, we cannot treat you.

In the future, we may change how we use and share information and so may change our Notice of Privacy Practices. If we do change it, you will be advised of this at your next appointment. A copy will be available for you to review in the waiting room at any time. You may also request a paper copy to take with you.

If you are concerned about some of your mental health information, you have the right to ask us not to use or share some of the information for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. We will try to respect your wishes, but we are not required to agree to any limitations. If we do agree, we promise to comply with your wish.

After you have signed this consent, you have the right to revoke it in writing. We will comply with your wishes about using or sharing your information from that time on; however, we may already have used or shared some of your information and cannot change that.

______________________ ____
DATE SIGNED (Patient 12+ years)

______________________ ____
DATE SIGNED (Parent/Guardian)

3416 Liberty Drive ● Springfield, IL 62704 ● (217) 793-3949 ● FAX (217) 793-3995