**Iler Consulting, LLC**

**Brenda Stockdale**

**6030 Bethelview Rd. Suite 403 Cumming, GA 30040**

**Office: *77*0.205.6068 Fax*: 77*0.205.8470**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patients Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Initial**

**\_\_\_\_:** I have received a copy of Iler Consulting’s Notice of Privacy Practices (HIPAA*)*

**\_\_\_\_:** I consent to allow Brenda Stockdale and staff to discuss my health issues with friends or family members or other health professionals that I have contact the office on my behalf.

\_\_\_\_: I specifically also allow these listed people to discuss my health issues with Brenda Stockdale and staff:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_: I do not wish to have my health issues discussed with anyone other than myself. *(Only check this line if you are excluding the above 2 HIPAA consent*s)

\_\_\_\_: I have read and agree with the Disclosure and Consent form.

\_\_\_\_: I have read and agree with the Policies and Procedures of Iler Consulting.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Patient Signature Date