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Dear Parents,

The federal government's Healthcare Insurance Portability and Accountability Act 1996 requires us to inform you of your right to confidential health care. Your consent to use Protected Health Information (PHI) will be requested. If at any time you wish to remove yourself from our mailing list, you may contact us directly. Your PHI includes: name, address, phone and fax numbers, email, evaluation and treatment notes, billing, and other healthcare information. Individuals within Pathway Programs, Inc. who may view PHI include: therapy providers, directors, accountants, a billing agency, and other professionals in training. Your doctor and private insurance company (including Medicaid) may view this information also to audit patient care. Your PHI will be used by Pathway Programs, Inc. (unless you opt out) for the following reasons: treatment and evaluation, routine operations, billing, training, notification of upcoming events, education of issues related to treatment, and personal written correspondence. If questions arise at any time, Coleen Stinson may be contacted at the above numbers for information. Your consent will expire in 6 years unless you opt out in written format sent to the above address.

I agree to the information provided above.

Parent/Guardian Signature: _____

Printed Name: _____ Patient Name: _____

Today's Date: _____