ACKNOWLEDGEMENT OF PRIVACY PRACTICES AND CONFIDENTIALITY IN THERAPY AND CLIENT RIGHTS DOCUMENTS

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My signature confirms that I have been informed of my rights to privacy regarding my protected health information (PHI), under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- ✓ Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- ✓ Obtain payment from third party payers for my health care services
- ✓ Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my provider's NOTICE OF PRIVACY PRACTICES AND CONFIDENTIALITY IN THERAPY AND CLIENT'S RIGHTS containing a more complete description of the uses and disclosures of my protected health information (PHI). I have been given the right to review and receive a copy of such NOTICE OF PRIVACY PRACTICES AND CONFIDENTIALITY IN THERAPY AND CLIENT'S RIGHTS. I understand that my provider has the right to change the NOTICE OF PRIVACY PRACTICES AND CONFIDENTIALITY IN THERAPY AND CLIENT'S RIGHTS and that I may contact this office at the address above to obtain a current copy of the NOTICE OF PRIVACY PRACTICES AND CONFIDENTIALITY IN THERAPY AND CLIENT'S RIGHTS.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Client Name:____ Date___________

Signature ____

Relationship to Client ____

Dependent family members also covered by this acknowledgement:

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For Office use only: __Client refused to sign __Communication Barriers __ER situation __ Other