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Notice of Privacy Practices Acknowledgement and Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information will be used to:

*Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.

*Obtain payment from designated third-party payers.

*Conduct normal health care operations such as quality assessments or evaluations, and physician certifications.

I have received a copy of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the opportunity to review such Notice of Privacy Practices prior to signing this consent.

I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

_____ _____

Signature Date Signed
(Parent/Guardian Signature if client is minor)

_____

Printed Name

_____ _____

Clinician Signature Date Signed