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Licensed Professional Counselor

Acknowledgement of Receipt of Disclosure and Notice of Privacy Rights and Policies
Signature Page

I have received, read and understand the Notice of Privacy Rights and Policies Documentation as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that his 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 the address above to obtain a current copy of the NOTICE OF PRIVACY PRACTICES.

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.

Print Name: _____

Date of Birth: _____

Signature: _____ Date: _____

If signed by Responsible Party, please state relationship to client and authority to consent:
