EVANS COUNSELING

Helping you to find your inner empowerment.

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. Federal and state law allows providers to use and disclose my protected information for purposes of treatment and care operations. The therapist will not disclose my record to others unless I direct him/her to do so or unless the law authorizes or compels him/her to do so.

I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this therapist has the right to change his/her Notice of Privacy Practices periodically and that I may contact the therapist at any time to obtain a current copy of the Notice of Privacy Practices.

By my signature below I acknowledge my receipt of the Notice of Privacy Practices.

Signature Date

Spouse Signature Date

Parent/Guardian Signature Date

This Form will be retained in your record.

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: Initials: Reason: