Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPAA), 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. Kindred Counseling 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 the 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.

My signature below acknowledges receipt of the Notice of Privacy Practices:

Printed Name/Signature Date

Printed Name/Signature Date

Parent/Guardian Printed Name/Signature Date