Notice of Privacy Practices
Acknowledgment of Receipt

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). I acknowledge that I have received or have been given the opportunity to receive a copy of Peg Hurley Dawson, LMHC, CSTS has the right to change its Notice of Privacy Practices and that I may contact any office to obtain a current copy of the Notices of Privacy Practices.

I further acknowledge that I have had a chance to ask questions about how my information will be used

Patient's Printed name _____ Date _____

Or

Patient's Signature _____

Patient's Representative (Printed) _____ Signature _____

This document will be filed in the patient's electronic medical record as required by HIPAA regulations. The Notice of Privacy practices will be provided upon request in alternative formats for individuals with disabilities or in a language other than English for people with limited English proficiency.