Acknowledgement of Receipt
Notice of Privacy Practices

By signing this form, you acknowledge that you have received our "Notice of Privacy Practices" (the "Notice"). This Notice describes in detail how we might use or disclose your protected health information. The Notice also discusses your rights and our duties with respect to your protected health information. You have the right to review the Notice before signing this acknowledgment.

By signing this form, you further acknowledge that medical information collected at Thrive Therapeutic Services (the "Clinic") will be stored in a medical record system operated by the Clinic, and kept securely in line with state and federal regulations.

_____ _____

Signature or Patient or Legally Authorized Representative Date

_____ _____

Printed Name of Patient or Legally Authorized Representative Relationship to Patient

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If the patient refused or was unable to acknowledge the Notice of Privacy Practices, please explain why:

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