HIPAA Acknowledgement of Receipt of Privacy Practices

Client Name: _____

Date: _____

Notice of Privacy Practices

Federal law (HIPAA – Health Insurance Portability and Accountability Act of 1996) requires that you are informed of how your health information may be used and disclosed, and how you can access this information.

Our Notice of Privacy Practices explains:
- How we may use and share your protected health information (PHI).
- Your rights regarding your health information.
- Our legal duties to safeguard your privacy.

You have the right to:
- Receive a paper or electronic copy of the Notice.
- Request restrictions on certain uses or disclosures of your information.
- Inspect and obtain a copy of your records.
- Request an amendment to your health record.
- File a complaint if you believe your privacy rights have been violated.

Acknowledgement

By signing below, you acknowledge that you have received, read, and/or been offered a copy of the Notice of Privacy Practices.

Client/Guardian Signature: _____ Date: _____

Provider/Witness Signature: _____ Date: _____