



HIPAA Acknowledgement and Consent Form

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can, and will, be used to conduct, plan, and direct my treatment and follow-up care among the multiple providers who may be involved in that treatment directly or indirectly. I understand that I have a right to privacy and that my healthcare information will never be shared with a non-therapist or physician, unless I have given my consent.

By signing below, I consent that I understand these privacy practices and my rights under HIPAA.

Patient Name (printed): _____

Patient Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

(in case of a minor)