Notice of Privacy Practices Receipt and Acknowledgement of Notice

Client Name ____

Federal regulations (HIPAA), allows Transitions Counseling to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for the services we provide, and for other professional activities (known as "health care operations"). The NOTICE OF PRIVACY PRACTICES DESCRIBES THESE DISCLOSURES IN MORE DETAIL. You HAVE THE RIGHT TO REVIEW THE NOTICE OF PRIVACY PRACTICES BEFORE SIGNING THIS CONSENT. WE RESERVE THE RIGHT TO REVISE OUR *NOTICE OF* PRIVACY PRACTICES AT ANY TIME. IF WE DO SO, THE REVISED NOTICE WILL BE POSTED IN THE OFFICE. You MAY ASK FOR A PRINTED COPY OF OUR NOTICE AT ANY TIME.

This consent is voluntary: You may refuse to sign it. However, we are permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked.

You may revoke this consent at any time by giving written notification.

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Transitions Counseling Privacy Practices. I understand that if I have any questions regarding the Notice of my privacy rights, I can contact Transitions Counseling staff at 2304 W. Bardin Road, Suite 202, Grand Prairie, Texas 75052

Client / Guardian Signature ________________________________ Date ________________