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Acknowledgement of Notice Of Privacy Practices (HIPPA) and Consent to Use and Disclose Your Health Information

This form is an agreement between (you) _____ and Juanita Mitchell, LMHC. When we use the words "you" and "your" below, this can mean you, your child, a relative, or some other person if you have written his or her name here: _____.

When I examine, assess, diagnose, treat, or refer a client, I will be collecting what the law calls "protected health information" (PHI) about that person. I need to use this information in my office to decide on what treatment is best for you and to provide treatment to you (or your child). We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

By signing this form as the client, parent, or guardian of said client, I acknowledge that I have read, understand, and agree to the terms and conditions of our privacy practices. **I understand the limits of confidentiality, privacy policies, my rights, and their meanings, and ramification and have been given the opportunity to address any questions or request clarification for anything that is unclear for me. I also understand and acknowledge the inherent privacy risks when communication if over the Internet.** After you have signed this consent, you have the right to revoke it by writing to me. I will then stop using or sharing your PHI, but please be advised I may already have used or shared some of it, and cannot change that.

_____ _____

Client's name (please print) Client's date of birth

_____ _____

Signature of client or personal representative Date

_____

Relationship to client

_____ _____

Signature of authorized representative of the practice Date

Date of NPP (HIPPA): _____ ❑ Copy declined by the client/parent/personal representative