Privacy Notice (HIPPA) Acknowledgement

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information maintained here at **Healing Hope Counseling Center, LLC (Healing Hope).** I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up with the multiple healthcare providers who may be involved in that treatment directly or indirectly.
2. Obtain payment from third party payers.
3. Conduct normal healthcare operations, such as, quality assessments and physicians certifications.

I have been informed by Healing Hope of my right to privacy and obtained a copy of the Privacy Notice, which contains a more complete description of the possible uses and disclosures of my health information. I was given the rith to review the Privacy Notice prior to signing this consent form. I understand that Healing Hope has the right to change its' Privacy Notice at any time and that I may contact the organization at any time in order to obtain a current copy of the Privacy Notice.

I also understand that if I need more information or have questions, I may contact Healing Hope a the number listed on the Privacy Acts Notice. I understand that Healing hope restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that Healing Hope is not required to agree to my requested restrictions, but if Healing Hope agrees to my restrictions, then the organization is bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except for the extent that Healing Hope has taken action relying on this consent.

Client/Guardian
Signature:_____Date:_____

Staff
Signature:_____Date:_____