JUDITH L. THURSWELL, PsyD, LP

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NOTICE OF PRIVACY ACKNOWLEDGEMENT

I understand that under the *Health Insurance Portability & Accountability Act of* 1996, (HIPAA) which came into effect on April 14, 2003, I have certain rights to privacy regarding my protected health information. (Whether I am participating in Individual, Couple, Family or Group Psychotherapy), I understand that this information can and may be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers, including for the purpose of consulting with a clinical supervisor, who may be involved in the treatment directly, or indirectly.
- Obtain private pay by check or cash, or payment from third party payers.
- Conduct normal health care operations such as quality assessments, professional audits and reviews, case coordination, case management and other administrative services.

I have received, read and understand the *Notice of Privacy Practices* containing a more detailed and complete description of the uses and disclosures of my health information. I understand that this practice has the right to change its *Notice of Privacy Practices* from time to time and that I may contact Dr. Thurswell at any time to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request and restrict in writing how my private information be disclosed to carry out treatment, payment or healthcare operations. I also understand that Dr. Thurswell is not required to agree to my requested restrictions, but if she does agree, that she is bound to abide by such restrictions.

Patient's Name_____

Patient's Parent/ Guardian Name:_____

Signature/Date:_____

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*PROVIDER USE ONLY: I attempted to obtain the patient's signature on this acknowledgement of information but was unable to do so, as specified below:

Provider's Name/Date_____