Signature ***required*** on this form.

LAURIE DANIEL, M.S., LPC, MHSP, NCC
Licensed Professional Counselor w/Mental Health Services Provider Designation
National Certified Counselor
Individual & Relationship Counseling
5100 Poplar Avenue, Suite 2700
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Acknowledgement of Receipt of a Copy of

NOTICE OF PRIVACY PRACTICES

Regarding Use & Disclosure of Personal Health Information (PHI)
According to the Health Insurance Portability & Accountability Act
(HIPAA), Effective Beginning April 14, 2003

I, the Client of the above-named Mental Health Care Provider, acknowledge that I have on the date below **read and received a copy** of the ten-page Notice of Privacy Practices, describing in detail my privacy rights, limits to privacy, and the obligations of the Mental Health Care Provider listed above as to how medical information about me may be used and disclosed and how I can get access to this information. I realize that my Mental Health Care provider is required by law to maintain the privacy of protected health information (PHI), information which may identify me and that relates to my mental health treatment and condition. The Notice describes how she may use and disclose my PHI in order to carry out treatment, payment, or health care operations and for other specified purposes that are permitted or required by law, as well as my rights and limits to my rights with respect to my PHI. I understand that she will not use or disclose my PHI without my written authorization, except as described in the Notice of Privacy Practices. I have agreed to carefully review this Notice.

______________________________________ ____________________

Client Name (Printed) Date

____

Client Signature