Sanctuary Christian Counseling
NOTICE OF PRIVACY ACKNOWLEDGEMENTS

I understand that, under the **HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 ("HIPAA"),** I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

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

I understand that this organization, Sanctuary Christian Counseling has the right to change its **NOTICES OF PRIVACY PRACTICES** from time to time and that I may contact this organization at any time at the address above to obtain a current copy of **NOTICE OF PRIVACY PRACTICES.**

I understand that *I may request in writing that you restrict how my private information is used or disclosed* to carry out treatment, payment or health care operations. I also understand you are not required to agree to my restrictions, but if you do agree then you are bound to abide by such restrictions.

CLIENT NAME: _____

PARENT/GUARDIAN (If under 14): _____

SIGNATURE: _____

TODAY'S DATE:_____ DATE OF BIRTH:_____

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement on this **NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT,** but was unable to do so as documented below:

Clinician's Signature:_____

Date: _____