Phoenix
COUNSELING SERVICES, LLC
717-778-1030

Client Name: _____ DOB: _____

Acknowledgement of HIPAA Privacy Notice

Phoenix Counseling Services, LLC is required by law to keep my information safe.

This information may include:

- Notes from your doctor, teacher or other healthcare provider
- Medical history
- Test results
- Treatment notes
- Insurance information

We are required by law to give you a copy of our privacy notice. This notice tells you how your health information might be used and shared. Please initial each line acknowledging below:

_____ I acknowledge that I have received a copy of Phoenix Counseling Services, LLC's HIPAA Notice of Privacy Practices that fully explains the uses and disclosures they will make with respect to my individually identifiable health information.

_____ I have had the opportunity to read the notice and to have any questions regarding the notice answered to my satisfaction.

_____ I understand Phoenix Counseling Services, LLC cannot disclose my health information other than as specified in the notice.

_____ I understand that Phoenix Counseling Services, LLC reserves the right to change the notice and the practices detailed therein if it sends a copy of the revised notice to the address I have provided.

_____ _____
printed name date

_____ _____
signature relationship to client