The Center for Psychological Wellness

Patient Name _____ DOB _____

SS# _____

I understand that a patient's health information is private and confidential. I understand that The Center for Psychological Wellness works hard to protect my privacy and preserve the confidentiality of my health information.

I understand that The Center for Psychological Wellness may use and disclose my personal health information to help provide health care to me, to handle billing and payments, and to take care of other health care operations. In general, there are not other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatens to hurt another person.

This office has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy and is attached to this Acknowledgement. I understand that I have the right to read the "Notice of Privacy Practices".

Within the Notice of Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but aren't limited to, access to my medical records: restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communications be by specified methods or alternative locations.

The Center for Psychological Wellness has established procedures which help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgements information, charges for copies and non-routine information needs, etc. I will assist the office by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

My signature below indicates that I have been given the chance to review a current copy of The Center for Psychological Wellness "Notice of Privacy Practices".

Patient or legally authorized individuals signature Date Time

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Relationship to patient(if signed by other then the Patient)