PSYCHOLOGY HEALTH GROUP

A Group of Independent Practitioners

Acknowledgement of Privacy Practices Policy

I acknowledge that I am aware of the Provider's Notice of Privacy Practices posted at Psychology Health Group which summarizes the ways my identifiable health information may be used and disclosed and states my rights with respect to my medical information. I understand that Psychology Health Group has the right to revise these information practices and to amend the Notice of Privacy Practices. I understand that in the event that the Notice is revised, the revised Notice will be posted at Psychology Health Group and I also understand that I may obtain a current Notice of Privacy Practices at any time from the office manager at Psychology Health Group.

_____ _____

Signature of Patient/Parent/Guardian/Representative Date Signed

_____

Printed name

_____

If guardian/representative-state relation to patient

Please print minor child(ren)'s name(s) below who are patients here:

_____ _____

Name DOB

_____ _____

Name DOB

_____ _____

Name DOB