Counseling Associates

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES &
AUTHORIZATION TO CONTACT BY TELEPHONE / VERBALLY IN THE EVENT OF BREACH OF PHI

By my signature below I, _____ acknowledge that I have read a copy of the Notice of Privacy Practices for Counseling Associates, and upon my request have received a copy of this notice. A copy of the Privacy Practices is available on the Counseling Associates website (www.counselingassociates.com).

Additionally, I authorize Counseling Associates to provide notice to me by telephone or verbally in the event of a breach of my protected health information (PHI) by Counseling Associates. Such conversation shall be documented by Counseling Associates.

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Final Rule modifying the HIPAA Privacy, Security, Enforcement and Breach Notification Rules, the verbal or telephonic notice provided to me pursuant to this authorization shall not be simply for the administrative convenience of Counseling Associates.

Signature of client (or personal representative) Date

If this acknowledgement is signed by a personal representative on behalf of the client, please complete the following:

Client's Name

Your Relationship to Client

For office use only
I attempted to obtain written acknowledgement of receipt of out Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other:

This form will be retained in your medical record.