**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES**

I understand that as part of my healthcare, Transitions Therapeutic Services of North Texas, PLLC, originates and maintains health records describing my health history, symptoms, evaluations and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professions.

Transitions Therapeutic Services’, *Notice of Privacy Practices* provides specific information and thorough description of how my personal health information may now be used and disclosed, I have been provided a copy of or access to the *Notice of Privacy Practices* and understand that I have been provided with a copy of the *Notice* and been given an opportunity to review the Notice prior to signing this consent. Before implementation of any revisions to this *Notice*, the revised *Notice* will be mailed to me if I provide my address below. I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment, or healthcare operations and that Transitions Therapeutic Services, is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that Transitions Therapeutic Services, has already taken action in reliance on my prior to consent. This consent is valid until revoked by me in writing.

Client:

( ) I request the following restrictions on the use and/or disclosure of my personal health information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

( ) I do not request any further restrictions on the use and/or disclosure of my personal health information than described in *Notice of Privacy Practices*.

Therapist:

( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, agrees to comply

( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, disagrees to comply. Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I further understand that any and all records, whether written, oral, or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

I have been provided and received Transitions Therapeutic Services’, *Notice of Privacy Practices* dated\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.