RENÉE DIVINE LMFT
Relationship & Sex Therapist

Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among multiple health care providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third party payers
- Conduct normal health care operations such as quality assessments and physicians certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that you have the right to change the *Notice of Privacy Practices* from time to time and that I may contact you at the address above to obtain a current copy of *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions.

In compliance with the federal Health Insurance Portability and Accountability Act, Renee Divine, MA, LMFT is restricted to making and/or canceling appointments by the CLIENT ONLY (with the exception of a parent calling for a minor child or written permission below).

I give permission to Renee Divine, MA, LMFT to speak with:

_____(name) who is my _____

(relationship), in the case of emergency. They can be reached at

_____(phone).

Client Name: _____

Signature: _____

Relationship to Client: _____
(If minor)

Date: _____

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