

**Center for Mind Body Health
17300 El Camino Real, St. 107D
Houston, Texas 77058
843-741-0266**

Notice of Privacy Practices Acknowledgement

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

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and professional certification and licensures.

I have received, read, and understand the HIPAA Notice of Privacy Practices containing a more complete description of the uses and disclosures of my personal health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at the address above to obtain a current copy of the practices.

I understand that I may request, in writing, that the practitioner restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that the practitioner is not required to agree to my request for restrictions, but if she does so she agrees to be bound by such restrictions.

Client name: _____

Signature: _____

Date: _____