Notice of Privacy Practices – Acknowledgment

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting this office.

Our notice of Privacy Practices describes in more detail how you health information may be used and disclosed, and how you can access your information.

As required by the privacy regulations, I am aware that Scher Center for Well-being has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

By my signature below I acknowledge receipt of the Notice of Privacy Practices. I provide Scher Center for Well-being, with my authorization and consent, to use and disclose my protected health care information for the purpose of treatment and health care operations as described in the Privacy Notice.

_____ _____

Signature of patient or authorized representative Date

_____ _____

Printed name if signed on behalf of patient Relationship (parent, guardian, etc.)

*This form will be retained in your health record