Acknowledgement of Privacy Rights

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

- Provide and coordinate my treatment among a number of health care providers who may be involved in the treatment directly or indirectly.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review such Notice of Privacy Practices. I understand that my provider has the right to change the Notice of Privacy Practices and that I may contact the massage clinic to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that the massage therapy clinic restrict how my private information is used or disclosed to carry out treatment, payment or other health care options. I also understand that the massage therapy clinic is not required to agree to my restrictions, but if the massage therapy clinic agrees then all parties involved are bound to abide by such restrictions.

Clients Name: _____ Date: _____

Signature: _____

Parent or Legal Guardian: _____

Relationship to Client: _____if other than parent or legal guardian.

Thank you for your cooperation.
Mind & Muscle Medicine, LLC

Therapist Signature: _____ Date: _____

Unable to obtain the clients written acknowledgement of the Notice of Privacy Rights due to the following: _____

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