

Christian Counseling

**DEBRA A. CIARLO, MEd., LMHC**

Licensed Mental Health Counselor

# **ACKNOWLEDGMENT OF PRIVACY PRACTICES**

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.
* Obtain payment from third-party payers for my health care services.
* Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my counselor’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 and receive a copy of such Notice of Privacy Practices. I understand that my counselor has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the 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, and I understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I give specific permission for communication from this office through the following modalities, as these are not encrypted forms of communication: Check all that apply.

(Please put an asterisk (\*) by your preferred form of communication)

Voice message systems on my home and/or cell phone number(s)

This specific email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Text messaging to my cell phone number(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Skype via computer, iPad, cell phone (video with voice)

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_