HIPAA Acknowledgement

Client's Name: _____ DOB: _____

HIPAA Notice of Privacy Practices

___ Copy Declined

___ Copy Received

Client Acknowledgement

We are required by law to maintain the privacy of protected health information, and to provide individuals with this Notice of our Legal Duties and Privacy Practices with respect to Protected Health Information. These legal duties and privacy practices are detailed in the **Client Information and Consent to Treat** document.

If you have any questions, please speak with either Shirley Zagorski or Lorraine Donnelly in person or by phone at our main number, 610-323-4673.

Based on Act 137, passed by the Pennsylvania State Legislature in 2005, it is LifeWorks Counseling Center, LLC's policy that minors aged 14-17 control consent to release of records. Therefore, this HIPAA Acknowledgement may be signed by a client age 14 or over, but must be signed by a Parent or Guardian if the client is under age 14.

Your signature below is only acknowledgement that you have been given the option of receiving a copy or been afforded an opportunity to review our Notice of our Privacy Practices:

To be completed by Client (if age 14 or over):

Print Name: _____

Signature: _____ Today's Date: _____

To be completed by Parent or Guardian (if client is under 14):

Print Name: _____ Relationship: _____

Signature: _____ Today's Date: _____

Authorization for Use or Disclosure of Health Information

Release of Medical History and Treatment Information

I authorize the following individual(s) to receive information pertaining to my medical history and treatment:

Name: _____ Relationship: _____ Ph #: _____
Name: _____ Relationship: _____ Ph #: _____

Client Acknowledgement

In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, I understand that:

1. I may revoke this authorization at any time, except to the extent where action has already been taken in accordance to the original authorization for disclosure. My revocation must be in writing, signed by me or on my behalf, and delivered to our office address. My revocation will be effective once received by the practice, LifeWorks Counseling Center, LLC.
2. A copy of this authorization may be used with the same effectiveness as the original.

This authorization replaces any prior written authorization I have made regarding the use, release, and disclosure of my medical information.

To be completed by Client (if age 14 or over):

Print Name: _____
Signature: _____ Today's Date: _____

To be completed by Parent or Guardian (if client is under 14):

Print Name: _____ Relationship: _____
Signature: _____ Today's Date: _____