Patient Name: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT HIPAA CONSENT FORM

This consent form allows Lynn A. Polizzi, LMSW, PLLC to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996. This information may be used or disclosed to carry out treatment, payment or health care operations.

Lynn A. Polizzi, LMSW, PLLC has provided me with a Notice of Privacy Practices, which more completely describes such uses and disclosures. It provided this notice prior to my signing this form in accordance with my right to review its practices before signing consent.

I understand that the terms of the Notice of Privacy Practices may change and that I may obtain revised notices by contacting Lynn A. Polizzi, LMSW, the Privacy Officer and owner of Lynn A. Polizzi, LMSW, PLLC.

_____ I hereby authorize that Lynn A. Polizzi, LMSW, PLLC may leave messages on my voicemail to confirm Initial appointments, and/or may speak with other members of my household and leave messages with them regarding my appointments. I have checked the following phones in which messages and/or text messages regarding appointments can be left on:

_____cell phone – write phone number here:

_____home phone - write phone number here:

_____work phone – write phone number here:

_____email address – write email here:

_____ I hereby authorize that Lynn A. Polizzi, LMSW, PLLC may disclose my mental health information to any Initial person(s) who accompany me to my appointment, and are present with me at the appointment while I meet with Lynn A. Polizzi, LMSW.

_____ I hereby authorize that Lynn A. Polizzi, LMSW, PLLC may disclose my personal health information to the Initial person who I have listed as my emergency contact.

_____ I hereby authorize that Lynn A. Polizzi, LMSW, PLLC may disclose my personal mental health information to the Initial following person(s):

_____

_____

I understand that at any time I have the right to revoke this consent provided that I do so in writing, but that Lynn A. Polizzi, LMSW, PLLC services may still use information to complete any actions that it began prior to my revoking consent and which rely on my protected health information. I understand that Lynn A. Polizzi, LMSW, PLLC may refuse service if I revoke this consent.

I understand that I have the right to request – now and in the future – how protected health information is used or disclosed to carry out treatment, payment and health care operations, and must be provided by me in writing. I understand that while Lynn A. Polizzi, LMSW, PLLC is not required to agree to my requested restrictions, if it does agree, it is bound by that agreement.

I understand that Lynn A. Polizzi, LMSW, PLLC may refuse me services if I refuse to sign this consent.

By my signature below, I affirm the above information.

Today's Date: _____

Signature of Patient: _____

Please print name here: _____

Signature of Parent (if minor) / Authorized Representative:

_____

Revised: 02/2014