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Receipt of Disclosure Notice

Client Name:
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I acknowledge that I have received a copy of the "Notice of Privacy Practices," and I have been given an opportunity to review this Notice. I understand that it is my therapist's policy to treat all health care information and records as confidential, and not to disclose such information unless authorized to do so. I understand that I have certain rights with respect to disclosure of my health care information, subject to certain disclosures that are permitted or required by law (as fully described in the Notice), for example:

- I have specifically authorized the disclosure
- The disclosure is permitted or required by law
- For treatment, payment and/or healthcare operations
- For insurance, disclosure of mental health diagnosis, dates and duration of treatment; progress notes and treatment plan, if requested by insurance company
- Reports of homicidal or suicidal intent with a plan
- Mandated reporting of suspected or known abuse or neglect of a child or incapacitated or dependent adult

I understand that it is my therapist's policy not to share any health care information with family or household members, except as specifically directed by the client or parent/ guardian.

Client Signature_____Date_____

Client Signature_____Date_____

Guardian Signature_____Date_____

Clinician Signature:_____ Date_____