HIPAA Receipt

Patient Acknowledge of Receipt

I, _____ (Print Name), have received a paper copy of the Notice Form, which informs me of my rights under the Health Insurance Portability and Accountability Act (HIPAA).

The Notice describes how psychological and medical information about me may be used and disclosed and how I can get access to this information. Rights covered in the Notice Form included my right to:

- Notice of the uses and disclosures of Protected Health Information (PHI)
- Request restrictions on the uses of PHI
- Request and receive PHI
- Inspect and copy PHI
- Amend PHI
- Receive an accounting of disclosures of PHI
- Receive a paper copy of Notice

You signature below acknowledges that you have read this notice and agree to its terms.

Patient's Signature: _____

Date: _____