Notice of Privacy Practices Notification

Name: ____

DOB:____

I acknowledge that I have been given a copy of the Notice of Privacy Practices, required under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice informs me of the privacy practices of Rasmussen Counseling LLC., and gives detailed information of who is authorized to obtain my records and how I may access my medical records.

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Signature Date

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Signature of Parent, Guardian or Personal Representative Date

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Client refused to accept Notice of Privacy Practices and did not agree to sign this form.

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Signature of Clinician