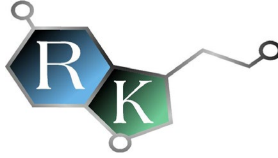

HIPAA Notice of Privacy Practices Acknowledgment Form

I acknowledge that I have received the HIPAA Notice of Privacy Practices (the "Notice") from RK Counseling PLLC ("RK Counseling") and that I have been provided an opportunity to review it. I understand that:

- I have certain rights to privacy regarding my protected health information.
- RK Counseling can and will use my health information for purposes of my treatment, payment for treatment, and health care operations.
- The Notice explains in more detail how RK Counseling may use and share my protected health information for other purposes.
- I have the rights regarding my protected health information listed in the Notice.
- RK Counseling has the right to change the Notice from time to time and I can obtain a current copy of the Notice by contacting the person listed in the Notice.

Name: ____________________________ Date:_____________________________

Signature: _________________________ Date of Birth:______________________

Relationship to Patient: _____________________________________

FOR OFFICE USE ONLY:

Good Faith Effort to Obtain Acknowledgment Form

Name of Patent: __________________________ Date of Birth: _________________

I attempted to obtain the patient's (or the representative of the patient) signature on the **HIPAA Notice of Privacy Practices Acknowledgment Form**, but was unable to do so, as documented below:

Reason: ____

Name: ____________________________ Date: ____________________________

Signature: ____