HIPAA

A Notice of Privacy Practices
Receipt and Acknowledgement of Notice

Patient/Client Name: _____

DOB: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Karen Hampton, LCSW's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice of my privacy rights, I can contact:

Depression and Anxiety Counseling of Austin
Karen Hampton, LCSW
12741 Research Blvd., Suite 300
Austin, Texas 78759
Ph: 512-339-1694
Fax: 512-835-9677
www.depressionanxietycounselingaustin.com

_____

Signature of Patient/Client **Date**

_____

Signature of Parent, Guardian, or Personal Representative* **Date**

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, legal guardian, etc.).

_____Client/Patient refuses to acknowledge receipt.

_____

Signature of Therapist **Date**