



HIPAA Acknowledgement

Patient's Name _____

Your signature below indicates that you have read this HIPAA Agreement and agree to its terms and also serves as an acknowledgement that you have received the HIPAA notice form described above

Patient Signature

____/____/____
Date

Signature of Personal Representative

____/____/____
Date

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided;

_____ Parent

_____ Guardian

Other: _____