

HIPPA NOTICE AND ACKNOWLEDGEMENT

I acknowledge that I have received/been offered the Notice of Privacy Practices.

Patient or Personal representative Signature _____
Date

If Personal Representative's signature appears above, please describe relationship to patient:

AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION

(Optional)

My protected health information may be disclosed to:

Name _____
Relationship

Name _____
Relationship

I understand that, as set forth in The Therapy Institute, LLC's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to:

The Therapy Institute, LLC
1660 Haslett Road – Suite 4
Haslett, Michigan 48840
ATTN: Privacy Officer

I understand that a revocation is not effective to the extent that The Therapy Institute, LLC has relied on the use or disclosure of the protected health information.

I understand that I have the right to

- Inspect or copy my protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization.

Signature of Patient or Personal Representative _____
Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority