Healing Hands Resource Center

Safe Place Clinics

Integrated Health Services

Name: DOB: Insurance ID No:

Acknowledgment of Receipt of Privacy Notice in Combination with Voluntary Consent for Uses and Disclosures of Protected Health Information (PHI) for Treatment, Payment, and Health Care Operations

Acknowledgment:

As a patient of Healing Hands Resource Center, I have been provided with its **Notice of Privacy Practices** which describes how health information about me may be used or disclosed and informs me of my individual privacy rights.

I acknowledge that I have received the Notice of Privacy Practices and understand how health information about me may be used, the duties of Healing Hands Resource Center and my rights to privacy protection and access to my health information. I understand that my therapist/case manager/counselor is available to answer any questions that I may have regarding issues of privacy.

Consent:

I give consent for health information about me to be used and disclosed for purposes of treatment, payment, or health care operations. I understand that the privacy regulations allow Healing Hands Resource Center to use or disclose my health information for these purposes and that my consent is not required. Healing Hands Resource Center is obtaining my consent to provide additional assurance regarding the privacy of my health information.

I understand that I have the right to make a request to revoke this consent and instead request a restriction on the use of my health information at any time. I further understand that Healing Hands Resource Center may choose not to agree to the request for a restriction on the uses or disclosures of my health information for purposes of treatment, payment, or healthcare operations.

To make a request to revoke my consent I must complete and sign a "Request to Restrict Uses and Disclosures of Protected Health Information" form and return it to my therapist/ case manager/counselor. I may obtain a copy of the form from my therapist/case manager/counselor at Healing Hands Resource Center

Client Name (printed) / Address	Phone number
Signature of Client (12 years and older)	Date
Signature of Legal Guardian/Parent	Date
Signature of Personal Representative of Client, if applicable, and title	Date
Witness	Date

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