Pediatric Behavioral Health Institute

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Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up with other healthcare provider who may be involved in my care directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessment and improvement, business management and general administrative activities.

I have received, read and understand the Notice of Privacy Practices containing a more complete description of the uses and disclosure of my heath information. I understand that the SEAL Therapeutic Corporation has the right to change its Notice of Privacy Practices and that I may contact this office at any time to obtain a current copy.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I understand you are not required to agree to my requested restrictions, but if you do agree then you are bound by such restrictions.

Patient Name (Print): _____

Signature of Patient: _____

Relationship to Patient: _____

Date: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date: _____ Initials: _____ Reason: _____