I acknowledge that I have been provided the Word of Life Counseling Center Notice of Privacy Practices (“Notice”):

* It tells me how Word of Life Counseling Center will use my health information for the purposes of my treatment, payment for my treatment, and Word of Life Counseling Center health care operations.
* The Notice explains in more detail how Word of Life Counseling Center may use and share my health information for other than treatment, payment, and health care operations.
* Word of Life Counseling Center will also use and share my health information as required/permitted by law.
* Word of Life Counseling Center may also exchange my health information for treatment purposes when participating in Health Information Exchange (HIE).

I consent to Word of Life Counseling Center using and disclosing my treatment records maintained by Word of Life Counseling Center for the purposes detailed in Word of Live Counseling Center Notice of Privacy Practices.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patient’s Complete Legal Name: | | | |  | | | | |
|  | | | (please print) | | | | | |
| Patient’s DOB | |  | | | Date: | |  | |
| Signature: |  | | | | | | | |
| (Patient or legal representative\*) | | | | | |  | |  |

\*May be requested to show proof of representative status

Office use only

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| I attempted to obtain the patient’s signature on this acknowledgement, but was unable to do so as documented below: | | | | | |
| Date attempted: |  | Name: |  | Reason: |  |