From the Counseling Office of **Tracy W. Thomas, LPC**

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**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES**

*This Notice of Privacy Practices was provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). This Notice describes how I may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases. Your “protected health information” means any of your written and oral health information, including demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health or condition.*

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, acknowledge receipt of Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act (HIPAA).

**CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION**

This form is an agreement between you, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and me, Tracy W. Thomas, LPC. When I use the word “you” below, it will mean you child, relative, or other person if you have written his or her name here \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

When I examine, diagnose, treat or refer you, I will be collecting what the law calls Protected Health Information (PHI) about you. I need to use this information here to decide on what treatment is best for you and to provide treatment to you. I may also share this information with others who provide treatment to you or in order to arrange payment for your treatment (with written permission) or if I receive a court order to do so.

By signing this form you are agreeing to let me use your information here and send to others as noted in the above paragraph. The Notice of Privacy Practices (NPP) explains in more details your rights and how we can use and share your information. Please read this before you sign this consent form. **If you do not sign this consent form agreeing to what is in the NPP I cannot treat you.**

In the future I may change how I use and share your information and so may change the NPP. If I do change it, you can get a copy from me. It will be posted in the waiting room of my office.

If you are concerned about some of your information, you have the right to ask me to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to agree to these limitations. However, if I do agree, I promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling me you no longer consent) and I will comply with your wishes about using or sharing your information from that time on but I may already have used or shared some of your information and cannot change that.

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Client Signature Date

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Client Name Date

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Tracy W. Thomas, LPC Date