Mary Alvarez, Ph.D.

Licensed Psychologist

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Notice of Privacy Practices and Acknowledgements

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

1. Conduct, plan, and direct my treatment and care among multiple healthcare providers who may be involved in direct and indirect treatment.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments, professional certification, and professional licensure.

I have received, read, and understood the HIPAA Notice of Privacy Practices, which describes in more detail the uses and disclosures of my personal health information. I understand that Dr. Alvarez may modify this Notice and I may contact Dr. Alvarez at the above address to obtain a current copy of the Notice and Privacy Practices.

I understand that I may request, in writing, that Dr. Alvarez restrict how my private health information is used or disclosed to manage treatment, payment of services, or other healthcare operations. I understand that Dr. Alvarez is not required to agree to my request for such restrictions, but if she agrees to such restrictions, she will be bound by such restrictions.

_____ _____

Signature of Client or Guardian Date

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Printed Name of Client of Guardian