Inclusivity Clinical Consulting Services

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RECEIPT AND ACKNOWLEDGMENT OF HIPPA NOTICE OF PRIVACY PRACTICES

Please read the ICCS HIPPA Notice of Privacy Practices before you sign this form; the Notice describes:

- *How your Protected Health Information (PHI) may be used and disclosed.*
- *How you can gain access to your PHI, and*
- *The practices ICCS takes to safeguard your PHI.*

I hereby acknowledge that I have received, and have been given an opportunity to read a copy of, Inclusivity Clinical Consulting Services' HIPPA Notice of Privacy Practices. I understand that if I have any questions regarding the Notice, or my privacy rights, then I can contact ICCS.

Signature of Client:

_____

Printed Name: _____Date: ____/____/ ____

Signature of Personal Representative (if other than client):

_____

Printed Name: _____ Date: ____/____/ ____

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.):

_____

ICCS has made a good faith effort to obtain the above acknowledgement. Person seeking services refuses to sign.

Provider signature: _____Date: ____/____/ ____

Printed Name: _____CA License #:_____