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HIPAA Acknowledgment

(Please keep a copy of this form for yourself)

By your signature below, you indicate that you have accessed and read the Document entitled "Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information" found on the website www.scottrothpsyd.com/forms and click on **HIPAA Privacy Notice.**

_____ _____
Signature of Patient (if 14 years old or older) Date

_____ _____
Print Your Name Above Birth Date

_____ _____
Signature of Parent/Guardian if under 18 years Date

_____ _____
Signature of other Parent/Guardian of Joint Custody Date