ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____ acknowledge that I have received a copy of AJ Psychiatry, PLLC. This notice describes how in AJ Psychiatry PLLC, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. Your information will be disclosed to your insurance company and physician for billing purposes and to federal and state reporting agencies. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on the consent.

_____ _____

(*Signature of patient or personal representative*) (*Date*)

_____

(*Relationship to patient*)