Client Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

_____ SS #: _____

This Privacy Practices Notice provides in detail the uses and disclosures of your Protected Health Information (PHI) that may be made by therapist Anne Norfleet, LMFT, my individual rights and the therapist's legal duties with respect to your PHI. This notice includes:

- This therapist is required by law to maintain the privacy of your protected health information.
- This therapist is required to abide by the terms of the Notice currently in effect.
- Types of uses and disclosures that this therapist is permitted to make for each of the following purposes: treatment, payment and health care options.
- A description of other purposes for which this therapist is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by the law.
- A description of other uses and disclosure that will be made only with your written authorization and you may revoke such authorization.
- Your individual rights with respect to protected health information and a brief description of how you may exercise these rights in relation to:
    - The right to complain to this therapist and to the Security of HHS if you believe your privacy rights have been violated, and that no retaliatory actions will be used against you in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of your protected health information, and that this therapist is not required to agree to requested restrictions.
    - The right to receive confidential communications of protected health information.
    - The right to amend protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notice of Privacy Practices from this therapist upon request.

Anne Norfleet, LMFT reserves the right to change the terms of Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. By signing this document you are stating that you have read, understand and agree to this acknowledgement of privacy practices.

Client Signature: _____ Date: _____

Parent Signature: _____ Date: _____
(If applicable)

Parent Signature: _____ Date: _____
(If applicable)

Therapist Signature: _____ Date: _____