HIPAA Acknowledgement and Authorization Form

*<u>**Please choose one option from each section and return to the Front Desk**</u>*

1) ☐ I have received a copy of Emerge Counseling Ministries' HIPAA Privacy Notice and agree to its terms.

OR IF YOU DECLINE TO TAKE THE COPY OF THE HIPAA PRIVACY NOTICE CHECK THE FOLLOWING BOX:

☐ I have been offered a copy of Emerge Counseling Ministries' HIPAA Privacy Notice and declined to take it.

2) I understand my right to privacy and confidentiality, and I authorize the following person(s)/ organization(s) to have access to the indicated information from Emerge Counseling Ministries:

____

Name Relationship to client

☐ Financial (copay/balance) ☐ Appointments (cancel/confirm/schedule)

____

Name Relationship to client

☐ Financial (copay/balance) ☐ Appointments (cancel/confirm/schedule)

OR IF YOU DO NOT WISH TO RELEASE ANY INFORMATION REGARDING FINANCE/APPTS. CHECK THE FOLLOWING BOX:

☐ Do <u>not</u> release financial or appointment information to anyone unless required by law.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance thereon. **This authorization (unless revoked in writing) expires at the termination of treatment**. This authorization is being executed at the client's request.

____

Signature of Client or Legal Guardian Date

____

Printed Name of Client Client's Date of Birth

____

Witness Signature Date

**Please Note: Your healthcare or payment for care will not be affected by whether you sign this authorization. A photocopy or facsimile of this authorization will have the same authority as the original.