BELL CENTER FOR ANXIETY AND DEPRESSION

# *Notice of Privacy Practices Acknowledgement*

The Bell Center for Anxiety and Depression Notice of Privacy Practices provides information about how Protected Health Information about me (the patient) may be used and disclosed. I understand that if the terms of the Notice change, an updated copy of the Notice will be available on the Bell Center for Anxiety and Depression's website and in the office at the time of my next visit.

I understand that I have the right to request restrictions on how my protected health information is used or disclosed for treatment, payment, or health care operations. The Bell Center for Anxiety and Depression is not required to agree to this restriction, but if it does agree, it will be bound by the agreement.

By signing this form below, I acknowledge receipt of the Notice of Privacy Practices.

Signature of Patient: _____

Patient's Name: _____

Date: _____

Signature of Guardian, Patient Advocate (if applicable): _____

Guardian or Patient Advocate's Name: _____

Relationship: _____

Date: _____