HIPAA (Health Insurance Portability and Accountability Act)
Acknowledgement of Receipt

By my signature, I acknowledge receiving a full copy of BRIDGING HARTS PSYCHOTHERAPY'S Privacy Policy. This policy outlines the duties of BRIDGING HARTS PSYCHOTHERAPY and my rights regarding the privacy of all Protected Health Information as required by HIPAA (Health Insurance Portability and Accountability Act).

_____ _____
Client Signature Date

_____ _____
Guardian Signature, if applicable Date

_____ _____
Staff Signature Date