

Jack Hannibal, MA, LMFT

Signature Page for HIPAA Information

All health care providers are required by law to inform patients of how communication about their medical care is exchanged among other health care providers, and other entities. Please read the HIPAA Information that this office has provided to explain the limits of confidentiality. Please then sign the statement below and return to the address above.

I have received the Health Insurance Portability and Accountability Act (HIPAA) Information that was provided by Jack Hannibal, MA, LMFT.

Client Name (please print): _____

Client Name (please print): _____

I acknowledge that I have received a copy of the Notice of Privacy Practices of:

_____ effective Sept 1, 2008
(Therapist's name)

Signature (client or authorized representative): _____

Signature (client or authorized representative): _____

Date: _____

Relationship/authority (if signed by authorized representative): _____