HARMONIA: MADISON CENTER FOR PSYCHOTHERAPY, L.L.C.

Receipt and Acknowledgment of Notice
Of Privacy Practices

Patient/Client Name:____
DOB: ____
SSN: (0ptional)____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Harmonia: Madison Center for Psychotherapy's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the Clinic Manager, Jennifer Parker, at 608-255-8838, ext. 6.

____
Signature of Patient/Client **Date**

____
Signature or Parent, Guardian or Personal Representative * **Date**

____
* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

❑ **Patient/Client Refuses to Acknowledge Receipt**:

____
Signature of Staff Member **Date**

AUTHORIZATION
Contact by Telephone/Verbally in Event of Breach of PHI

I, ______________________________ authorize Harmonia: Madison Center for Psychotherapy to provide notice to me by telephone or verbally in the event of a breach of my protected health information (PHI) by Harmonia. Such conversation shall be documented by Harmonia in my chart.

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Final Rule modifying the HIPAA Privacy, Security, Enforcement and Breach Notification Rules, the verbal or telephonic notice provided to me pursuant to this authorization shall not be simply for the administrative convenience of Harmonia: Madison Center for Psychotherapy.

____
Signature of Patient/Client Date

____
Signature of Parent, Guardian or Personal Representative Date

Adapted from NATIONAL ASSOCIATION OF SOCIAL WORKERS
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