

**Humanistic Resources, P.C.
Ron Rice, PHD
32910 W. 13 Mile Road
Suite D-402
Farmington Hills, MI48334**

Acknowledgement Receipt of Notice of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information.

____ I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Humanistic Resources, P.C. has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

____ I acknowledge that I have been offered your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information, but have declined a personal copy. I understand I may request a copy of your Notice of Privacy Practices at a later date.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____