The Jones Center for Children's Therapy and Assessment
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Patient Acknowledgement of the Health Insurance Portability and Accountability Act (HIPAA)

Patient Name: _____ Date of Birth: _____

I acknowledge I have reviewed the Jones Center for Children's Therapy and Assessment (JCCTA) Patient Privacy Notice (Notice) which provides detailed information concerning the uses and disclosures of my/my child's Protected Health Information (PHI) by JCCTA, my individual rights, how I may exercise these rights, and JCCTA's legal duties regarding my/my child's PHI.

I understand JCCTA reserves the right to change the terms of its Notice. If changes to this notice occur, JCCTA will provide a copy of the revised Notice upon request.

_____ _____
Signature of authorized representative Relationship to Patient