



PRIVACY PRACTICES ACKNOWLEDGEMENT

In accord with Federal Regulations related to the Privacy of Medical Treatment, Village Family Psychiatry, PLLC will make every effort to insure the privacy of your Medical Record and your treatment in our offices.

Your signature attests to having been given the opportunity to read and review the “Notice of Privacy Practices” of Village Family Psychiatry, PLLC. If requested, I attest to having received a copy of this “Notice of Privacy Practices”. If I did not request a copy, I attest to understanding the basic components outlined in the “Notice of Privacy Practices” and have been given opportunity by the clerical/administrative staff and/or my doctor/therapist to explain any portion that is unclear to me.

I am aware that I have the right to file a complaint with the Village Family Psychiatry, PLLC privacy officer, Teresa Harris, and that said complaint will be handled in accord with the “Notice of Privacy Practices” and will in no way jeopardize my/our treatment with the doctor/therapist with whom I/we work.

Name of Patient

Signature of Patient/Legal Guardian

Date

Signature of Witness

Date