LAURIE KIMMEL, LMSW, PLLC

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND AUTHORIZATION TO CONTACT BY TELEPHONE / VERBALLY IN THE EVENT OF A BREACH OF PHI

By my signature below I,_____ acknowledge that I have read a copy of the Notice of Privacy Practices for Laurie Kimmel, LMSW, and upon my request have received copy of this notice.

Additionally, I authorize Laurie Kimmel, LMSW, to provide notice to me by telephone or verbally in the event of a breach of my Protected Health Information (PHI) by Laurie Kimmel, LMSW. Such conversation shall be documented by Laurie Kimmel, LMSW.

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPPA) Final Rule modifying the HIPPA 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 Laurie Kimmel, LMSW.

By typing my signature on the line below I am agreeing that I have read, understand and agree to the items contained in this document.

Signature of patient_____ date_____

If this acknowledgment is signed by a personal representative on behalf of the patient, please complete the following:

_____

Patient's Name

_____

Your Relationship to the Patient