

AppleTree Therapy Services, LLC.
Acknowledgement of Receipt of Privacy Practices
Effective Date: 6/1/2009

I, _____ (name of patient or guardian), hereby acknowledge receipt of the Notice of Privacy Practices for AppleTree Therapy Services, LLC. I hereby grant authority to AppleTree Therapy Services, LLC to obtain, copy, and release for review protected health information (PHI), for the purpose of evaluation, treatment, and diagnosis of _____
_____ (name of patient).

I understand that AppleTree Therapy Services, LLC reserves the right to modify or change the Notice of Privacy Practices. I also understand that a copy of any change will be provided to me or made available to me.

This authorization will remain in effect until such time that treatment by AppleTree Therapy Services, LLC has been terminated.

Printed name of client

Date of birth

Signature of client or guardian

Date

If you are not the client, please state your relationship to the client