# Autism Clinic

SPEECH THERAPY & TRAINING CENTER

JOIN • PLAY • GROW

2552 E. Kenosha St.
Broken Arrow, OK 74014
Main 918-893-3735
Fax 918-893-3745
Stephanie Barton MED CCC-SLP
Lori Frederick, Executive Director

## ACKNOWLEDGEMENT OF RECEIPT

## OF PRIVACY PRACTICES NOTICE

This acknowledgement, which allows The Griffin Promise Autism Clinic staff to use and/or disclose personally identifiable health information for treatment, payment or healthcare operations, is a requirement of the federal privacy regulations for the Health Insurance Privacy and Accountability Act (HIPAA) of 1996.

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by The Griffin Promise Autism Clinic for the purposes of treating, obtaining payment for treatment and in order to carry out any healthcare operations that are permitted by this Act.
2. I am aware that The Griffin Promise Autism Clinic maintains a Privacy Notice regarding the types of uses and disclosures that are permitted to be made under the Privacy Act. By signing this acknowledgement, I understand that I have received a copy of the Privacy Notice.
3. I understand and acknowledge, The Griffin Promise Autism Clinic has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to submit a written request to The Griffin Promise Autism Clinic 2552 E. Kenosha Broken Arrow, OK 74014; Attention: Office Manager.
4. I understand and acknowledge that I have the right to request that The Griffin Promise Autism Clinic how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that The Griffin Promise Autism Clinic is not required to agree to restrictions requested by me.

I request the following restrictions placed on The Griffin Promise Autism Clinic's use and/or disclosure of my health information (leave blank if no restrictions are requested at this time):

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I acknowledge that I have reviewed a copy of The Griffin Promise Autism Clinic's Notice of Privacy Practices and agree to The Griffin Promise Autism Clinic's use and disclosure of my protected health information for treatment, payment, and healthcare operations.

Signature of Patient or Legal Guardian_________________________________________

Date________________________________