

Susan J Bloom Psy D, APNP, LLC

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

I, _____ authorize Susan J Bloom LLC to give me notice verbally if my Protected Health Information (PHI) has been breached. If ever there were a breach, this breach shall be documented Susan J Bloom LLC in my record.

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPPA) final rule modifying the AIPPA Privacy, Security Enforcement and Breach Notification Rules, the verbal or telephone notice provided to me pursuant to this authorization shall not be simply for the administrative convenience of Susan J Bloom LLC.

If I am self-paying for services, I have the right to not have any information disclosed to my health plan regarding my treatment.

_____ I am self-paying for treatment _____ I am not self-paying for treatment

I hereby acknowledge that I have a copy of the Notice of privacy practices.

Signature of Patient

Date

Signature of Parent/Guardian

Date

Signature of Witness

Date