480-331-6867
info@cedarnsagewellness.com
10335 N Scottsdale Rd Suite F
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HIPAA Privacy Practices Acknowledgment Form

Client Name:_____ DOB:_____

Notice of Privacy Practices

Your privacy is important to us. As a healthcare provider, we are required by law to maintain the privacy and confidentiality of your protected health information (PHI). Our **Notice of Privacy Practices** outlines how your information may be used or disclosed for treatment, payment, healthcare operations, or when required by law.

You have the right to:

- Review and receive a copy of the Notice of Privacy Practices.
- Request restrictions on certain uses and disclosures of your PHI.
- Request that communications regarding your health information be made by alternative means or to an alternative location.
- Access, inspect, and request corrections to your health records.

Acknowledgment of Receipt

I acknowledge that I have received and/or been offered a copy of the **Notice of Privacy Practices** for this massage therapy practice. I understand that my personal health information will be handled in accordance with HIPAA and state privacy laws.

Signature of Client: _____ Date: _____

If signed by a legal guardian or representative:
Name: _____Relationship to Client: _____

Therapist/Provider Use Only

☐ Client received Notice of Privacy Practices
☐ Client declined to receive the notice Staff Initials: _____Date:_____