**Laara Israhel, LMFT PRIVACY POLICY**

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability act of 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future. To comply with one of HIPAA’s requirements we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

From time to time it may be necessary for us to make disclosures of your information in connection with our treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

**Patient Acknowledgement and Consent**

I acknowledge that I have today received a copy of the Notice of Privacy Practices (electronically and can request a paper copy). I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Print Patient Name (or Guardian) Patient Signature Date**

**Patient Consent**

This authorization is effective today and shall remain in effect indefinitely. However, at any time you can Laara Israhel, LMFT’s right to

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Print Patient Name (or Guardian) Patient Signature Date**

**I also give consent for information pertaining to my treatment, appointments, insurance benefits, and financial arrangements to be discussed with the following individuals: (e.g. spouse, parent, adult child, care giver):**

Relationship: Date of Birth:

1

Relationship: Date of Birth:

**2**

The following circumstances prohibited the patient from signing the Acknowledgement:

An emergency situation prevented the patient (parent/guardian) from signing the Acknowledgement.

Office Personnel (signature) Office Personnel (print name) Date:

LAARA ISRAHEL, LMFT #50309 1162 15th Street, Los Osos, CA 93402