Scheffler
Psychological Associates

Patient Acknowledgement Form:
Use & Disclosure of Protected Health Information (PHI)
(HIPAA Acknowledgement Form)

Heather B. Scheffler, Ph.D., has provided me with a copy of her "**Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information.**" I understand that this notice describes how Dr. Scheffler and Scheffler Psychological Associates may use and disclose protected health information (PHI) as it pertains to my mental health treatment.

By signing this form, I consent to Dr. Scheffler's business policies and use and disclosure of protected health information (PHI) about me for treatment, payment, and health care operations. I understand that I have the right to revoke this consent, in writing, except where Dr. Scheffler has already made disclosures in trust prior to my request.

_____ _____

Signature of parent, guardian, or authorized representative Date

_____ _____

Signature of patient/client Witness

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