

Young Minds Psychiatry LLC

Notice of Privacy Practice Acknowledgement

I understand my health information is private and confidential. Young Minds Psychiatry LLC will make continuing effort to protect the privacy and confidentiality of my personal health information.

I understand that Young Minds Psychiatry may use and disclose my personal health information to provide mental health care, to handle billing and payment, and to take care of other mental health care operation. (There will be no other disclosures of this information unless I specifically authorize it. I understand that rarely the law may require the release of my information without my authorization.)

Young Minds Psychiatry has detailed policy called the "Notice of Privacy Practices." It contains information about protecting my privacy. This "Notice of privacy Practices" may be updated as needed and copy will be available upon request. I will assist Young Minds Psychiatry by following office procedures (written request, reasonable time for completion and copying and paying the charges where indicated) if I choose to exercise any of my authorization for release of information, record of disclosures, and communication by the available method of my choice.

My signature below indicated that I have read and understand a current copy of Young Minds Psychiatry LLC " Notice of Privacy Practices."

Patient or Legally Authorized Signature

Date

Relationship to patient (if Applicable)

Date