WINS*i*

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that the Notice of Privacy Practices for the Western Institute for Neurodevelopmental Studies and Interventions (WINSi) contains detailed information about how WINSi may use and disclose my protected health information. I understand that I may request in writing that WINSi restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that WINSi is not required to agree to my requested restrictions, but if WINSi does agree, then it is bound to abide by such restrictions.

I acknowledge that I have received a copy of the Notice of Privacy Practices. I understand that WINSi has the right to change its Notice of Privacy Practices and that a current copy of this Notice will be posted in a visible location at WINSi's office. I also acknowledge that that I may contact WINSi at any time to obtain a current copy of this Notice.

I acknowledge that I have read and fully understand the Notice of Privacy Practices of the Western Institute for Neurodevelopmental Studies and Interventions (WINSi). I consent to all terms set forth in this Notice. I understand that I may revoke this consent in writing at any time, except to the extent that WINSi has taken action relying on this consent.

_____ _____/_____/_____

Signature of Patient or Legal Guardian *Date*

_____ _____

Printed Name of Patient or Legal Guardian *Relationship to Patient*