Fern River Psychiatry

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand and acknowledge that Fern River Psychiatry, LLC is obligated to keep my health information confidential, but legally may use my health information for purposes of treating me, getting paid for services provided to me, or for the internal operations of the Practice such as improving care and treatment services. I understand that a detailed list of permissible uses and disclosures is included in Fern River Psychiatry, LLC's Notice of Privacy Practices which has been provided to me, and which also can be found on the Practice website www.fernriverpsychiatry.com.

By signing below, I acknowledge that I have read the above information, and that I understand and agree to the above statements, have been given the opportunity to have my questions about this form answered, and have been given the opportunity to have my questions about the Notice of Privacy Practices answered.

_____ _____

Signature of Patient or Authorized Representative | Date / Time

_____ _____

Printed Name of Patient or Authorized Representative | Relationship of Authorized Representative

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