For Notice with effective date of October 1, 2013.

NOTICE OF PRIVACY PRACTICES----ACKNOWLEDGEMENT

I, Clarissa Hill, functioning as Clarissa Hill PLLC, will keep a record of the health care services I provide to you, the patient. You may ask to see and copy that record. You may also ask to correct that record. I will not disclose your record to others unless you direct me to do so or unless the law authorizes or compels me to do so. You may see your record or get more information about it by contacting Clarissa Hill M.A., LMHC, Ph: (206) 504-1704.

My **Notice of Privacy Practices** describes in more detail how the health information may be used and disclosed, and how you can access your information.

By my signature below I _____ (please print patient name), hereby acknowledge receipt of the **Notice of Privacy Practices**.

PATIENT SIGNATURE _____ DATE _____

(Or Patient Representative. Indicate relationship if signing for patient.)

THERAPIST SIGNATURE _____DATE _____

This form will be retained in your medical record.