COMBINED ACKNOWLEDGEMENT AND CONSENT

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Read before signing the Acknowledgement and Consent

This acknowledgement of notice and consent authorizes Patience D. Stevenson, D.Min., LMFT, LPC to use and disclose health information about you for treatment, payment and healthcare operations purposes.

Notice of Privacy Practices. Patience D. Stevenson, D.Min., LMFT, LPC has a Notice of Privacy Practices, which describes how I may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review my current notice prior to signing this acknowledgement and consent.

Amendments. I reserve the right to change my notice of Privacy Practices and to make the terms of any change effective for all protected health information that I maintain, including information obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to me, as the Privacy Officer:

How to contact Privacy Officer

Patience D. Stevenson, D.Min., LMFT, LPC

539 Center Street

Bethlehem, PA 18018-5910

610-248-5587

Acknowledgement and Consent

Please print all information except signature.

I have received the Notice of Privacy Practices for Patience D. Stevenson, D.Min., LMFT, LPC, and authorize her to use and disclose health information about me,

_____ (patient name)

for treatment, payment, and healthcare operations purposes consistent with my Notice of Privacy Practices.

_____ _____

Signature of Client (or personal representative Date

_____ _____

Name of personal representative Relationship to client