

NOTICE OF PRIVACY PRACTICES

UPDATED: 2/24/2020

I, _____, have received from Hope & Help a copy of the "Notice of Privacy Practices." I understand that Hope & Help may need to use and disclose information about my health or medical problems for the purpose of arranging, conducting, or referring for my treatments, for obtaining payment for the services rendered to me and for the operations of the practice. I consent to the use of my information for the purposes of treatment, payment and healthcare operations. Hope & Help reserves the right to modify the privacy practices outlined in the notice.

Patient's Signature_____
Date_____
Parent or Guardian Signature
(for minors under 18 years old)_____
Date