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Receipt of HIPAA Notice of Privacy Practices

I have received this practice's HIPAA Notice of Privacy Practices. This Notice provides in detail the uses and disclosures of my Protected Health Information (PHI) in my psychotherapy record. I have received information about my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its HIPAA Notice of Privacy Practices, and to make changes regarding all PHI residing at, or controlled by this practice. I understand I can obtain this practices HIPAA Notice of Privacy Practices upon request.

Client's printed name	Client's date of birth
Client's signature	Date
Client's printed name	Client's date of birth
Client's signature	Date
Parent's or legal guardian's printed name	
Parent's or legal guardian's signature	Date