

**Comprehensive Psychiatry Group, Inc.
NOTICE OF PRIVACY PRACTICES**

I, the undersigned patient (or parent / guardian of a minor patient), do hereby attest that Comprehensive Psychiatry Group, Inc. provided me with a copy of its HIPAA NOTICE TO PRIVACY PRACTICES.

HIPAA, (the Health Insurance Portability and Accountability Act of 1996), requires that effective April 14, 2003 all health care providers present their patients with a copy of the health provider's Privacy Practices.

By signing below, I attest only that I was indeed provided with a copy of the Privacy Practices. The HIPAA Notice of Privacy Practices handout is mine to review and keep. This form will be kept as a permanent part of my medical record at Comprehensive Psychiatry Group, Inc.

(signature of patient / parent / guardian)

(date)

