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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand and acknowledge that *psychiatrie.me PLLC* is obligated to keep my health information confidential, but legally may use my health information for purposes of treating me, getting paid for services provided to me, or for the internal operations of *psychiatrie.me*, such as improving care and treatment services. I understand that a detailed list of permissible uses and disclosures is included in the *psychiatrie.me* Notice of Privacy Practices that can be found on the practice website at *www.psychiatrie.me*.

By signing below, I acknowledge that I have read the above information, and that I understand and agree to the above statements, and that I have been given the opportunity to have my questions about this form and the Notice of Privacy Practices satisfactorily answered by *psychiatrie.me* or its physicians.

_____ _____

Signature of Patient Date

_____

Printed Name of Patient

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