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Receipt of Psychologist-Patient Services Agreement and Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information

I have received a copy of the "Psychologist-Patient Services Agreement" and "Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information." I understand that it is a violation of DC law, as well as of the Ethical Principles of the American Psychological Association, for a psychologist to divulge any information regarding the treatment of his or her clients. I understand that I must authorize the release of any part of my *PHI* and that I can revoke that authorization at any time. In addition, I understand that there are certain instances when information may be disclosed without my consent. They include information about imminent child abuse, adult or domestic partner abuse, a serious threat to the health and safety of myself or another, as well as other specific instances such as psychology board oversight, judicial proceedings, and treatment involving workmen's compensation.

I understand and accept the policies and procedures described above.

Patient name_____

Signature_____ **Date**_____

Responsible party_____

Signature_____ **Date**_____