Amber Baker, Ph.D.
Clinical Psychologist

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RECEIPT AND ACKNOWLEDGMENT OF HIPAA NOTICE OF PRIVACY PRACTICES

Please read Dr. Baker's HIPAA Notice of Privacy Practices before you sign this form; the Notice describes:

- *How your Protected Health Information (PHI) may be used and disclosed.*
- *How you can gain access to your PHI, and*
- *Dr. Baker's practices to safeguard your PHI.*

I hereby acknowledge that I have received, and have been given an opportunity to read a copy of, Dr. Baker's HIPAA Notice of Privacy Practices. I understand that if I have any questions regarding the Notice, or my privacy rights, then I can contact Dr. Baker.

Signature of Client:

____

Printed Name: ____ Date: ____/____/ ____

Signature of Personal Representative (if other than client):

____

Printed Name: ____ Date: ____/____/ ____

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.):

____

Dr. Amber Baker has made a good faith effort to obtain the above acknowledgement.

□ Person seeking services refuses to sign.

Dr. Amber Baker: ______________________________________ Date: ____/____/ ____
CA License # PSY 24533