



**Acknowledgement of Review of  
Notice of Policies and Practices to Protect the Privacy of Your Health  
Information**

I have reviewed and received a copy of Austin Family Counseling's' Notice of Policies and Practices to Protect the Privacy of my Health Information, which explains how my health information will be used and disclosed.

\_\_\_\_\_  
Signature of Patient or Personal Representative/ Guardian

\_\_\_\_\_  
Print Name of Patient or Personal Representative/ Guardian

\_\_\_\_\_  
Description of Personal Representative/ Guardian's Authority

\_\_\_\_\_  
Date