ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY RIGHTS

By signing below, I hereby acknowledge receipt, on this date, of the Notice of Privacy Rights, under the provisions of the Health Insurance Portability and Accountability Act: ("HIPAA"). The University of Central Arkansas Speech Language Hearing Center has provided this document to me.

I have been advised that except for evaluation and treatment, payment matters and clinic operations, under HIPAA, protected health information will not be disclosed without my written authorization.

_____ _____

Printed Name Signature

_____ _____

Client's Name Date