**Acknowledgement of Receipt of Notice of Privacy Practices**

I acknowledge that I have been provided Building Blocks Therapy’s Notice of Privacy Practices. It tells me how Building Blocks Therapy will use my health information for the purposes of my treatment, payment for my treatment, and Building Blocks Therapy’s health care operations. The Notice explains in detail how Building Blocks Therapy may use and share my health information for other than treatment, payment, and health care operations. I understand that Building Blocks Therapy will also use and share my health information as required by law.

Client’s Legal Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client/ Client’s Parent or Legal Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization to Video/ Audio Record**

I hereby authorize Building Blocks Therapy to record myself and/ or child through video and audio technologies. Building Blocks Therapy has explained and I understand the following:

* Building Blocks Therapy will use/ disclose any video/ audio recording for the purpose of treatment (therapeutic interventions) or as required by law,
* Building Blocks Therapy will maintain and make secure all video recordings consistent with federal and state privacy and security laws involving protected health information.
* Building Blocks Therapy will destroy any video and/ or audio recordings consistent with federal and state privacy and security laws governing the disposing of protected health information,
* The video and audio recordings may be used by Building Blocks Therapy during group treatment sessions, and
* The video and audio recordings, at the time of group treatment session, will be viewed and heard by other individuals participating in the group treatment session,

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_

I understand that I can revoke this authorization at any time by writing to Megan Lesko, Building Blocks Therapy; PO Box 943; Camp Hill, PA 17001-0943.

I also understand that:

I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal.

I am entitled to receive a copy of this authorization.

Client or Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_

Name of Representative (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_