



HIPAA Acknowledgment and Consent

I, the undersigned, acknowledge that I have had access to a copy of Therapies of the Rockies, LLC. **NOTICE OF PRIVACY PRACTICES.**

I consent to disclosures, which you deem necessary in connection with my or my child's condition. This information will only be distributed to my funding agency or third party payer for purposes of reimbursement for services provided, and only upon direct request of my third party payer.

Print Name of Patient (or responsible party)

Date

Signature of responsible party

Date