Health Insurance Portability and Accountability Act Agreement

Patient Name: ____

Your signature below indicates that you have read the Barrington Behavioral Health and Wellness PC HIPPA Agreement and agree to its terms and also serves as an acknowledgement that you have received the HIPPA notice form described above which can also be referred to at www.barringtonBHW.com

________________________________ _____________

Patient Signature Date

________________________________ _____________

Signature of Personal Representative Date

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided;

____ Parent

____ Guardian

Other:____