

**Patient Written Acknowledgment Confirming Receipt of Notice of Privacy Practices**

Healthy Habitudes, LLC

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I have received Healthy Habitudes, LLC Notice of Privacy Practices that gives a more complete description of information uses and disclosures and understand that Healthy Habitudes, LLC may share my protected health information for treatment, payment, and healthcare operations. I understand that I have the right to review the notice prior to signing this acknowledgment. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

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Client Signature

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Print Name

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Date

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Signature of Client Representative (if client under 18 and/or unable to sign)

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Relationship of Representative to Client