HIPAA Acknowledgment

I acknowledge that **Happy Hands Therapy Services** has supplied me with a copy of their health information privacy notice regarding their policies concerning my Protected Health information.

I agree to release authorization to **Happy Hands Therapy Services** for the purpose of treatment, billing and communication.

For Patient: _______________________________

Initial Here______: If you approve of receiving medical related information via email (ex. Completed evaluations, updates from therapists and invoices)

E-MAIL: ____

Please list below any additional people (such as another therapist, school or daycare provider) that you would like to allow Happy Hands Therapist's to communicate with in order to further help your child:

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____ ____________________

Parent/Legal Guardian Signature **Date**

2106 Rue Simone Hammond, LA 70403
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