DR. DAPHNE TIMMONS PhD.

SOUTH CAROLINA PRIVACY NOTICE FORM

Notice of Policies and Practices to Protect the Privacy of Your Health Information

I have read and received the information contained in this document and understand how the Health Insurance and Portability and Accountability Act (HIPAA) impacts clinical and medical information about me and how I can get access to this information. I am also aware that should I have any questions concerning this policy I am free to discuss them at our next session or at any time in the future.

_____
SIGNATURE AND DATE

_____
PRINTED NAME

_____
WITNESS