KJ Hurt, Licensed Professional Counselor
HIPAA (Health Insurance Portability and Accountability Act)
Acknowledgement of Receipt

By my signature, I acknowledge receiving a full copy of KJ Hurt's Privacy Policy. This policy outlines the duties of KJ Hurt, LPC, and my rights regarding the privacy of all Protected Health Information as required by HIPAA (Health Insurance Portability and Accountability Act).

_____	_____
Client Signature	Date
_____	_____
Guardian Signature, if applicable	Date
_____	_____
Therapist Signature	Date