ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
&
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Name_____

Children's Name(s)_____

Address
_____**Telephone**_____

TO THE PARENT OR GUARDIAN GIVING CONSENT, PLEASE READ FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, insurance claims, and healthcare operations.

Notice of Privacy Practices: You have received and have had the opportunity to read our Notice of Privacy Practices before you decide whether to sign the Consent. Our Notice provides a description of our treatment, payments activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Compliance Officer, Acadia Health LLC
Address: 5151 Plank Road, Baton Rouge, La. 70805
Phone: 225-330-6622 Fax: 225-356-8163

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature Below Acknowledges Receipt of Notice of Privacy Practices and Consent for the Use and Disclosure of Your Health Information:

I, (Please Print Name) _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my child's protected health information to carry out treatment, payment activities and health care operations and other uses described in the Notice of Privacy Practices that was provided to me.

Signature: _____ Date: _____