

**NOTICE OF THE POLICIES AND PRACTICES TO PROTECT THE
PRIVACY OF YOUR HEALTH INFORMATION**

Eugene Kranz, Ph.D. CA PSY Lic # 23155

I received the Notice of Privacy Practices from Dr. Kranz regarding his privacy policies and practices as outlined by HIPAA (Health Insurance Portability and Accountability Act of 1996, revised effective September 23, 2013). I have read the Notice and Dr. Kranz discussed the information with me. I am familiar with Dr. Kranz's abilities and limitations protecting my health information.

By signing this form, I acknowledge receipt of Dr. Kranz's Notice of Privacy Practices and agree to let him collect and use my PHI for the purposes described in the Notice.

Signature of Patient (or parent/guardian)

Date

Printed Name of Patient (or parent/guardian)