

PATHWAYS

Center for Learning & Behavioral Health, LLC

Notice of HIPAA Policy

I, _____ acknowledge that PATHWAYS, Center
(Print First and Last Name)

for Learning & Behavioral Health, LLC's "Notice of Policies and Practices to Protect the Privacy of Your Health Information" has been made available to me. I am aware that I may obtain a copy of the policies at any time.

Signature of Patient (16 yrs of age and older)

Date

Signature of Parent/Guardian

Date