

Dr. Sharon Phillips and Associates, LLC

8050 Beckett Center Drive

Suite 216

West Chester, OH 45069

(513) 860-0801

HIPAA SIGNATURE FORM

(Rev. 2/12)

I acknowledge that I have read and understood the HIPAA Ohio Notice Form as provided by my therapist, and that I have been given a written copy of the document, if desired.

Client's Printed Name

Client's Signature (or parent, if child is under age 18)

Today's Date