



**HIPAA – CLIENT ACKNOWLEDGEMENT OF REVIEW AND RECEIPT  
Notice of HIPAA & GITRE Privacy Practices**

Printed Name of Client: \_\_\_\_\_

Client Birth Date: \_\_\_\_\_

Printed Name of Legal Guardian (of minor) \_\_\_\_\_

Notice Provided by: Gil Institute for Trauma Recovery & Education, LLC

All private practice mental health providers contracted by Gil Institute for Trauma Recovery & Education, LLC are required by law to maintain the privacy of and provide individuals with the attached Notice of our legal duties and privacy practices with respect to your Protected Health Information (PHI). If you would like a hard copy of the Notice to review at home, please ask your provider directly.

A copy of this Notice is also available on our website, [www.gilinstitute.com](http://www.gilinstitute.com)

I hereby acknowledge that I have reviewed the HIPAA Notice of my Privacy Rights and have been provided the opportunity to ask my provider questions about its' content.

\_\_\_\_\_  
Signature of client, or legal guardian of minor client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of client, or legal guardian of minor client

\_\_\_\_\_  
Printed name and signature of minor child  
*(if applicable, based on age/situation and at clinician's discretion)*

\_\_\_\_\_  
Signatory's relationship to client