



**Rehabilitation
Services, Inc.**
Physical, Speech-Language,
and Occupational Therapy

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HIPAA NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT FORM

By signing below, I acknowledge that I have been provided RSI's Notice of Privacy Practices, which contains a detailed description of the uses and disclosures of my health information and I have been given an opportunity to read the Notice.

Signature: _____ Date: _____

Print Name: _____

Signature of Authorized Representative (if signing for patient):

OFFICE USE ONLY

If unable to obtain the patient's signature in acknowledgement of receipt of the HIPAA Notice of Privacy Practices, document the reason below (emergency etc.)

Patient Name: _____ Date: _____

Reason: _____