BLUE SKY RANCH
HORSES • HOPE • HEALING

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I acknowledge that I have been provided the BSR Therapy Services Notice of Privacy Practices

It tells me how BSR Therapy Services will use my health information for the purposes of my treatment and health care operations.

The Notice explains in more detail how BSR Therapy Services may use and share my health information for other than treatment and health care operations.

BSR Therapy Services will also use and share my health information as required/permitted by law.

I consent to BSR Therapy Services using and disclosing my treatment records maintained by BSR Therapy Services for the purposes detailed in the BSR Therapy Services Notice of Privacy Practices.

Patient's Complete Legal Name: _____

Patient's DOB: _____ Date _____

Signature Patient or legal representative: _____