

**Adoption Related Services of Pinellas**  
**8800 49<sup>th</sup> Street N. Suite 212 ♦ Pinellas Park, FL 33782**  
**Fax: (727) 865-5178**

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**CLIENT RIGHTS AND RESPONSIBILITIES &  
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

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|--------------------|--|----------------------|--|
| <b>CLIENT NAME</b> |  | <b>DATE OF BIRTH</b> |  |
|--------------------|--|----------------------|--|

I am acknowledging that I have been given adequate opportunity to read/review and understand the following documents:

- Client Rights and Responsibilities
- Notice of Privacy Practices

I understand that my protected health information contained within the designated record set may be used and/or be disclosed for purposes of carrying out treatment, obtaining payment, and carrying out other administrative operations of the organization.

I acknowledge that I

- have received a copy of these documents
- am not requesting a copy of these documents at this time

I understand that I may request a copy of these documents at any point in treatment.

I also understand that my signature does not mean that I have read these documents in their entirety or that I agree with them. By signing below, I hereby voluntarily and knowingly consent to allow Adoption Related Services of Pinellas and any of its physicians, counselors, employees and/or agents, to use and/or disclose my protected health information as deemed appropriate to carry out treatment, payment and/or other administrative operations of the organization.

\_\_\_\_\_  
Signature of Client (If minor, Parent and/or Legal Guardian/Authorized Representative must also sign)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent / Legal Guardian / Authorized Representative (circle all that apply)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent / Legal Guardian / Authorized Representative (circle all that apply)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Counselor / Witness

\_\_\_\_\_  
Date