NeuroHope of Indiana, Inc.
6002 Sunnyside Rd.
Indianapolis, IN 46236
www.neurohopewellness.org

Notice of Privacy Practices

By signing this form, I acknowledge that I have read and that I understand NeuroHope of Indiana's Notice of Privacy Practices and Patient Rights and Responsibilities. This authorization expires at the end of the current calendar year.

Accordingly, I hereby consent to therapy/treatment at NeuroHope and the Uses and Disclosures of my Protected Health Information as described in Section III. I give authorization to NeuroHope to release and/or discuss information regarding my outpatient care to:

_____ I do not authorize the release of my private health information

_____ I authorize _____ Relationship _____
(Name of authorized person)

via in person discussion, email, or phone _____
(Circle preference) (Provide preferred contact information of authorized person)

I also acknowledge that other NeuroHope clients and caregivers may witness my treatment program at the clinic. I will be given a private room upon request.

Subject Name (Printed) Date

Subject Signature Date

Caregiver/Power of Attorney Name (Printed) Date

Caregiver/Power of Attorney Signature Date