CLOCKTOWER
PSYCHOLOGICAL ASSOCIATES, LTD

Patient Name _____

Your signature below indicates that you have read this HIPAA Agreement and agree to its terms and also serves as an acknowledgement that you have received the HIPAA notice.

_____ ____/____/____

Patient Signature Date

_____ ____/____/____

Signature of Personal Representative Date

If the authorization is signed by personal representative of the patient, a description of such representative's authority to act for the patient must be provided;

_____ Parent

_____ Guardian

Other _____