

**Notice of Privacy Practices
Receipts and Acknowledgement of Notice**

Patient/Client Name: _____

DOB: _____

Social Security Number: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of the Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Karen Bradley, LCPC, the Privacy Officer.

Signature of Patient/Client

Date

Signature of Parent, Guardian, or
Personal Representative

Date

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual, (power of attorney, healthcare surrogate, etc.)

Patient/Client refused to acknowledge receipt:

Signature of Staff Member

Date