**Form of Written Acknowledgment of Receipt**

**of Notice of Privacy Practices**

I certify that I have received a copy of the Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills, or in the performance of the therapist’s health care operations. The Notice of Privacy Practices also describes my rights and the therapist’s duties with respect to my protected health information.

The practice reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting the revised copy be sent in the mail, or asking for one at the time of my next appointment.

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Client, or Legal Representative, Signature

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Printed Client, or Legal Representative, Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

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Acknowledgement **NOT** obtained because:

\_\_\_\_\_Client, or Legal Representative, declined Notice of Privacy Practices,

\_\_\_\_\_Other (briefly describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Therapist Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name