# ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES & CLIENT RIGHTS AND RESPONSIBILITIES

I have reviewed this office's Notice of Privacy Practices, which explains to me how my medical and health information may be used and disclosed. I have also reviewed my rights and responsibilities as a client receiving counseling services through Andrea Johnson LPC, NCC. I understand that I am entitled to receive a copy of these documents at my request.

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient or Personal Representative

_____ _____

Counselor's Signature Date