Counseling and Education Services

ACKNOWLEDGEMENT OF RECEIPT:
NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices provides information about how we may use and disclose protected health information about you.

I acknowledge that I have received a copy of the Providers 'Notice of Privacy Practices'.

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____
Print Name Relationship to Patient

_____
Interpreter (if applicable)

Written Acknowledgement Not Obtained

Notice of Privacy Practices Given – Patient Unable to Sign
Notice of Privacy Practices Given – Patient Declined to Sign
Notice of Privacy Practices Mailed to Patient – Awaiting Signature
Other Reason Patient Did Not Sign

_____

_____