

Acknowledgment of Receipt of Notice of Privacy Practice

I acknowledge that I have received the Notice of Privacy Practices of the Provider.

I understand that such Notice informs me of my rights with respect to my Protected Health Information, as defined in the Notice, and describes the circumstances under which my Protected Health Information may be shared.

Name of Client: _____

Date of Birth: _____

Signature of Client: _____

Date: _____

Signature of Parent, Guardian or Responsible Party of a Client who is a Minor: _____

If Personal Representative, indicate relationship: _____

Date: _____

Refusals

[] The Client refused to accept a copy of the **Notice of Privacy Practices**.

[] The Client received a copy of the **Notice of Privacy Practices** but refuses to sign. ~~refused to sign the Acknowledgment of Receipt of Notice of Privacy Practices.~~

Witnessed by: _____

Date: _____