ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the client's medical decisions relative to the treatment situation.

I, _____ (*client*), hereby acknowledge that

_____ (*therapist/practice*) has either offered me or provided me with a copy of the **Notice of Privacy Practices** that describes how information about me may be used and disclosed, and how I can access this information. I understand if I have questions or complaints, I may contact:

_____ (*therapist/practice*).

I also understand that I am entitled to receive updates upon request if _____ (*therapist/practice*) amends or changes the **Notice of Privacy Practices** in a material way.

_____ _____

Client Signature Date

_____

Relationship to Client (*if signed by someone other than client*)

_____

Printed Name

IF SIGNATURE OBTAINED FROM PERSON OTHER THAN A LEGALLY RESPONSIBLE INDIVIDUAL, ACTION TAKEN TO OBTAIN LEGAL SIGNATURE:

- ☐ Given to above signee
- ☐ Sent via U.S. Mail
- ☐ Advised person that policy is available on our website at: _____

In either situation the parent/legal guardian must sign and return this form either in person or by mail to:

_____

_____

Attn: HIPAA

THIS SECTION IS TO BE COMPLETED BY MENTAL HEALTH PROVIDER

I made a good faith effort to obtain a written acknowledgement of receipt of the **Notice of Privacy Practices** from the above-named client, but was unable to because:

- ☐ Client declined to sign this Written Acknowledgement.
- ☐ Other (specify): _____

_____ _____

Therapist Signature Date

_____

Printed Name and Title