

NOTICE OF PRIVACY PRACTICES RECEIPT AND ACKNOWLEDGMENT OF NOTICE

Patient/Client Name: _____

DOB: _____

SSN: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Sandra A. Hope's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice of my privacy rights, I can contact Sandra Hope.

Signature of Patient/Client Date

Signature of Parent, Guardian or Personal Representative* Date

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

Patient/Client Refuses to Acknowledge Receipt:

Signature of Counselor Date