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**ACKNOWLEDGMENT OF RECEIPT  
OF NOTICE OF PRIVACY PRACTICES**

Client Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

By signing below, I acknowledge that I have received a copy of this practice's Notice of Privacy Practices and have therefore been advised of how this practice may use and disclose my protected health information and how I may obtain access to and control this information.

I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to psychotherapy notes, HIV-related information, and alcohol and substance abuse treatment information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Relationship to client (if signed by a personal representative of the client):

\_\_\_\_\_

form updated 11-01-07