NOTICE OF PRIVACY PRACTICES
RECEIPT AND ACKNOWLEDGMENT OF NOTICE

Patient/Client

Name:_____

DOB:_____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Linda Wirth's privacy practices. I understand that if I have any questions regarding the notice of my privacy rights, I can contact Linda Wirth, LCSW.

_____

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 Staff Member Date