Notice of Privacy Practices

Receipt and Acknowledgment of Notice

Patient/Client Name:_____

DOB: _____ / _____ / _____

I hereby acknowledge that I have received and been given an opportunity to read a copy of Rachel E.S. Wright, LCSW's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Rachel E.S. Wright at 312-508-3435.

_____

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:

_____

Rachel E.S. Wright, LCSW *Date*