THE THERAPY CENTER FOR WELLNESS & RECOVERY LLP

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY RIGHTS

I acknowledge that I have received the Notice of Privacy Practices of the Provider.

I understand that such Notice describes how my Protected Health Information, as defined in the Notice, may be shared, and that the Notice informs me of my rights with respect to my PHI.

Name ____

Date of Birth ____

Signature of Client ____

Printed name of Client____

Refusals

________ The Individual refused to accept a copy of the Notice of Privacy Practices.

_________ The individual received a copy of the Notice of Privacy Practices but refuses to sign an Acknowledgement of Receipt.

Signature of Provider Representative ____