RECEIPT AND ACKNOWLEDGMENT OF HPAA PRIVACY PRACTICES

Client: _____

DOB_____/_____/_____ SSN_____-_____-_____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Colleen Tredway's **Notice of Privacy Practices**. I understand that if I have any questions/concerns regarding this Notice or my privacy rights, I am free to ask my therapist who will provide me with answers to my questions/concerns.

_____ _____/_____/_____
Signature of 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

_____ _____
Therapist/Witness Date