

To comply with Federal HIPPA regulations concerning safety of Health Care Information, we provide every client with the opportunity to read our Notice of Privacy Practices. I am providing you with a copy for you to read and take with you. The signing of this form acknowledges that you had the opportunity to do so.

**Acknowledgment of Receipt of Privacy Notice**

**Client's Name:** \_\_\_\_\_

**Date of First Service:** \_\_\_\_\_

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Family Life Counseling's Notice of Privacy Practices by receiving the form in the office.

I understand that if I have any questions regarding this Notice of Privacy Practices or of my privacy rights, I can contact my therapist, Carol A. Larson, M.A.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Legal Relationship to Client