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**Notice of Privacy Practices
Receipt and Acknowledgment of Notice**

Patient/Client Name: _____

DOB: _____

SSN: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Julie Luzarraga's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Julie Luzarraga, LCSW, DCSW.

Signature of Patient/Client

Date

Signature or 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