Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client Name:_____

DOB: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of **Rachel Zielinski LCSW's** Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257.

_____

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**