KOLOB COUNSELING

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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/or have been given an opportunity to read a copy of **KOLOB COUNSELING** *Notice of Privacy Practices* and *How Medical Information May Be Used and Disclosed*. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Martha Ham, LCSW at (435) 674-4464.

_____
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**