RECEIPT OF NOTICE OF PRIVATE PRACTICES

NAME_____

My signature on this form acknowledges that I have received a copy of Lake City Counseling's LLC Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which myt health information may be used or disclosed by Lake City Counseling, LLC and of my rights in regard to my health information.

I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

Signature_____Date_____

_____ Date_____
Signature of Representative if customer is unable to sign

To be completed below by Lake City counseling staff if form is not signed.

1. Was the customer provided wit a copy of the Lake City Counseling Notice of Privacy Practices? ___ yes ____no

2. Briefly describe efforts made to obtain the customer's acknowledgement of receipts of the Notice and explain why the patient was not able or willing to sign this form:
   _____
   _____
   _____
   _____

   _____ Date_____
   Staff Signature