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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Client Name: _____

Date of Birth: _____

I have received Louis Hoffman, PhD, PC's Notice of Practice written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices upon request.

Signature: _____

Date: _____

(Include relationship to Patient if signed by a personal representative of the client.)