Chestnut Hill College
Psychological Services Clinic

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of the CHC Psychological Services Clinic's *Notice of Privacy Practices*. I understand the Clinic's privacy practices, legal duties, and my own rights concerning the use of my personal and health information.

____
Client's Name (printed)

______________________________ ________
Client's Signature Date

If signed by Personal Representative:
Signature:___________________________
Printed Name:______________________
Relationship to Patient:______________
Date:______________________________

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For internal office use only:

If not signed, reason:

□ Patient refused to sign □ Other____
□ Patient not able to sign (give additional information below regarding disability, emergency situation, etc.)

Comments:
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______________________________________ ___________________
Name of Reviewer Date