ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

_____ _____

Patient/Client Name *Date of Birth*

I have been provided a copy of the Columbus Speech & Hearing Center's Notice of Privacy Practices for review and was given the opportunity to ask questions about how the Center may use and/or disclose my individually identifiable health information. I understand that I may request a written copy of the Center's Notice of Privacy Practices at any time.

_____ _____

Signature of Patient/Client (or parent if applicable) *Date*