



Acknowledgment of Receipt of the Notice of Privacy Practices

Patient/Client Name _____

Date of Birth _____

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

Signature of Patient/Client (or parent if applicable)

Date

