CDCW

COUNSELING AND DIAGNOSTIC CENTER OF WOODFIELD, LTD.

# Acknowledgment of Privacy Practices

I, _____, whose date of birth is ____/_____/_____

hereby acknowledge that I have been given and received an opportunity to read a copy of Counseling and Diagnostic Center of Woodfield, Ltd.'s HIPAA Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Counseling and Diagnostic Center of Woodfield, Ltd., at: (847) 884-0210, ext. 201.

_____ _____

**Signature of Patient/Client** **Date**

_____ _____

**Signature or Parent, Guardian, Personal Representative *** **Date**

_____

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (*e.g.,* power of attorney, healthcare surrogate, etc.) and provide a written copy of said authority.

❑ **Patient/Client Refuses to Acknowledge Receipt**:

_____ _____

**Signature of Staff Member** **Date**