



RECEIPT OF NOTICE OF PRIVATE PRACTICES

NAME \_\_\_\_\_

My signature on this form acknowledges that I have received a copy of Healing Hearts Family Counseling Center, LLC Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by Healing Hearts Family Counseling Center, LLC and of my rights in regard to my health information.

I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

Signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Representative if customer is unable to sign Date \_\_\_\_\_

To be completed below by Healing Hearts Family Counseling Center, LLC counseling staff if form is not signed.

1. Was the customer provided with a copy of the Healing Hearts' Notice of Privacy Practices?    \_\_\_ yes    \_\_\_ no
2. Briefly describe efforts made to obtain the customer's acknowledgement of receipts of the Notice and explain why the patient was not able or willing to sign this form:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Staff Signature Date \_\_\_\_\_