

**Notice of Privacy Practices  
Receipt and Acknowledgment of Notice**

**Patient/Client Name:** \_\_\_\_\_  
**DOB:** \_\_\_\_\_

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Edmondson Counseling Services' Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Connie Edmondson, LCSW at 405-843-1551.

\_\_\_\_\_  
**Signature of Patient/Client** **Date**

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

\* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

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

\_\_\_\_\_  
**Signature of Staff Member** **Date**