HIPAA

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Center for Learning and Behavioral Solutions Privacy Practices.

Patient Name:_____
First Middle Last

Patient Signature:_____ Today's date:_____

If the patient is a minor.

Parent or Guardian (circle one):

I (full name), _____ , am the representative for the client.

Signature:_____ Today's date:_____

Center for Learning & Behavioral Solutions, Inc.
33 Creek Road, Suite 320, Irvine, CA 92604
Phone: (949) 654-2424 Fax: (949) 654-2428 www.centerforlearning.net

Copyright, Center for Learning & Behavioral Solutions, Inc., 2006