

JOY SHIVAS MSW LCSW BCD
NOTICE OF PRIVACY PRACTICES
RECEIPT AND ACKNOWLEDGMENT OF NOTICE

Patient/Client Name: _____

Date of Birth: _____

Social Security Number: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of JOY SHIVAS MSW Notice of Privacy Practices; I understand that if I have any questions regarding the Notice or my privacy rights, I can contact JOY SHIVAS MSW or DELLA WRIGHT.

Signature of Patient/Client _____ Date _____

Signature of 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 _____

