

# COUNSELING SERVICES OF CORTLAND

## Notice of Privacy Practices Receipt and Acknowledgment of Notice

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

**DOB:** \_\_\_\_\_

**SSN:** \_\_\_\_\_

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Counseling Services of Cortland's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact my clinician at (607) 662-0209.

\_\_\_\_\_  
**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**