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Doctor of Education in Counseling Psychology
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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 James M. Benedick's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice of Privacy Rights, I can contact Dr. Benedick.

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:

James M. Benedick, LCSW, Ed.D **Date**