An equal opportunity university

Counseling Training Clinic
Department of Psychology

Bellingham, Washington 98225-9172
(360) 650-3881 Fax (360) 650-2843

Acknowledgement of Receipt of Notice of Privacy Practices

Client Name: ________________________________ Medical Record #__________________________

Address: ____

Facility Name: WWU Counseling Training Clinic

I have been given a copy of the WWU Counseling Training Clinic's Notice of *Privacy Practices ("Notice")*, which describes how my health information is used and shared. I understand that the WWU Counseling Training Clinic has the right to change this Notice at any time. I may obtain a current copy by contacting the WWU Counseling Training Clinic at 360-650-3881, or contacting the WWU Privacy Officer.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

______________________________________ ____________________________
Signature of client or client representative Date

____
Print name

____
Client Representative Relationship to Client (e.g. Mother, father, Guardian, Health Care Power of Attorney)

For the WWU Counseling Training Clinic's use only: **Complete this section if you are unable to obtain a signature.**

1. If the client or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:
   ____
   ____
2. Describe the steps taken to obtain the client's (or personal representative's) signature on the *Acknowledgement*:
   ____
   ____

Completed by:

_____________________________________ ____________________________
Signature of the WWU Counseling Training Clinic's Representative Date

____
Print Name

BB