

**WASHINGTON NOTICE OF PRIVACY PRACTICES**

**ACKNOWLEDGEMENT**

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I keep a record of the health care services I provide you. The Washington Notice Form, sent to you when I emailed you the intake paperwork or offered at our first session, describes in detail how your health information may be used and disclosed and how you can access your information.

**By my signature below I acknowledge:**

Please check ONE:

\_\_\_\_\_ I have received a copy of the Washington Notice Form of Privacy Practices that went into effect April 14, 2003.

\_\_\_\_\_ I chose not to receive a copy of the Washington Notice Form of Privacy Practices that went into effect on April 14, 2003.

\_\_\_\_\_  
Signature of Client/Patient or legally authorized individual

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship to patient  
(self, parent, legal guardian, personal representative)

\_\_\_\_\_  
Counselor's Signature

\_\_\_\_\_  
Date

***This form will be retained in your medical record.***