

**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 Jewish for Good's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Jenny Schwartz at 919-354-4936.

\_\_\_\_\_  
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