



**ACKNOWLEDGEMENT OF RECEIPT OF THE  
NOTICE OF PRIVACY PRACTICES**

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

\_\_\_\_\_  
*Date of Birth*

I have been provided a copy of the Columbus Speech & Hearing Center's Notice of Privacy Practices for review and was given the opportunity to ask questions about how the Center may use and/or disclose my individually identifiable health information. I understand that I may request a written copy of the Center's Notice of Privacy Practices at any time.

\_\_\_\_\_  
*Signature of Patient/Client (or parent if applicable)*

\_\_\_\_\_  
*Date*

Receipt of NPP.doc - kd