MENTAL HEALTH SOLUTIONS S.C.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient's Name: _____

Date of Intake: _____

My signature on this form acknowledges that I have been offered a copy of Mental Health Solutions' Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my protected health information may be used or disclosed by Mental Health Solutions as well as my rights with respect to my protected health information.

I have been provided with the opportunity to discuss any concerns I may have regarding the privacy of my protected health information.

_____ _____
Patient's Signature Date

_____ _____
Signature of Patient's Representative if Patient is Unable to Sign Date

TO BE COMPLETED BY ADMITTING CLINICIAN IF FORM IS NOT SIGNED

Was the patient offered a copy of the Notice of Privacy Practices?
_____ Yes _____ No

Briefly describe the efforts made to obtain the patient's acknowledgement of the receipt of the Notice of Privacy Practices and explain why the patient was unable or unwilling to sign this form:

_____
_____
_____
_____