HIPAA

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Center for Learning and Behavioral Solutions Privacy Practices.

Patient Name:
First Middle Last

Patient Signature: Today's date:

If the patient is a minor:

Parent or Guardian (circle one):

I (full name), _____ , am the representative for the client.

Signature:_____ Today's date:_____

Please check how you prefer to receive correspondence, including reports, from C4L:

☐ Fax; fax number

☐ Email;

Be advised that Center for Learning's email server is secure but we cannot guarantee that the recipient's server is also secure. Correspondence and reports from C4L may include sensitive information.

Changes made to the above fax or email will need to be made in writing to Center for Learning.

Center for Learning & Behavioral Solutions, Inc.
16220 Scientific Way, Irvine, CA 92618
Phone: (949) 654-2424 Fax: (949) 654-2428 www.C4L.net