CENTER POINT
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 Center Point Notice of Privacy Practices, or have read the Notice of Privacy Practices on Center Point's website. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Center Point, at 3584 Atlanta Highway, Suite D, Flowery Branch, GA 30542 (678) 316-1009.

Signature of Patient / Client **Date**

Signature of 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**