Jim Cosenza, LCSW, CADC

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Receipt and Acknowledgment of Notice of Privacy Practices

Name (Legal): _____
First Name Middle Initial Last Name

Address: _____
Street Apt. Number City State Zip

Date of Birth: _____ SSN: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Jim Cosenza, LCSW, CADC's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Jim Cosenza, LCSW, 4753 N. Broadway, Suite 608, Chicago Illinois 60640.

Signature of Patient or Legally Authorized Patient Representative **Date**

Relationship to Patient

Jim Cosenza, LCSW, CADC **Date**

or

Refusal of Notice of Privacy Practices

☐ Patient/Client refuses to Acknowledge Receipt

Jim Cosenza, LCSW, CADC **Date**