



Pittsford Youth Services, Inc.

Notice of Privacy Practices

Receipt and Acknowledgment of Notice

Patient/Client Name: _____

DOB: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Pittsford Youth Services, Inc.'s ~ Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can submit a question, concern or complaint in writing to Jill Lennox (Pittsford Youth Services Administrator) or the Secretary of the Department of Health and Human Services at:

The U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Telephone: 202-619-0257

Toll Free: 1-877-696-6775

Signature of Patient/Client

Date

Signature or 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:

Clinician

Date