

## Acknowledgement of the Notice of Privacy Practices

### **Acknowledgement of Cornerstone Health Counseling Notice of Privacy Practices**

The signature below acknowledges receipt of the Cornerstone Health Counseling Notice of Privacy Practices only.

\_\_\_\_\_  
Signature of Client/Client Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Client/ Representative

\_\_\_\_\_  
Relationship to Client (if applicable)