SOUTHWEST FAMILY
GUIDANCE CENTER & INSTITUTE

NAME: ______________________

DOB: ______________ **ID #:** ______________

Receipt Of Notice Of Privacy Practices And Notice Of Confidentiality Of Alcohol And Drug Abuse Patient Records

CLIENT NAME **DOB**

GUARDIAN NAME AND RELATION TO CLIENT (IF CLIENT IS LESS THAN 14 YEARS OF AGE, A PARENT/GUARDIAN **MUST** SIGN.)

I have received a copy of the NOTICE OF PRIVACY PRACTICES and the NOTICE OF CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS.

SIGNATURE **DATE**

—OR—

I have chosen **not** to receive a copy of the NOTICE OF PRIVACY PRACTICES and the NOTICE OF CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS.

SIGNATURE **DATE**

SWFGC INTAKE THERAPIST SIGNATURE **DATE**

SWFGC INTAKE THERAPIST PRINTED NAME WITH CREDENTIALS