**Andrew R. Tidrick, LCSW**

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**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 Andrew Tidrick, LCSW’s Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Andrew Tidrick, LCSW at (970) 818-9332, Ext. 7.

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**Signature of Patient/Client Date**

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**Signature or Parent, Guardian or Personal Representative \* Date**

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\* 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**:

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**Signature of Staff Member Date**