Acknowledgement of Receipt of Notice of Privacy Practices

Printed Name of Patient _____ Date of Birth _____

I acknowledge that I have had the opportunity to review Linden Oaks Behavioral Health Patient Rights and Responsibilities.

Signature of Patient or Personal/Legal Representative _____ Date _____

If personal or legal representative, indicate relationship to patient:

_____

Time Arrived: _____

Linden Oaks
BEHAVIORAL HEALTH