ADVANCED BEHAVIORAL CENTERS OF DUPAGE

ACKNOWLEDGEMENT OF THE HIPAA PRIVACY NOTICE

By signing below I acknowledge that I was offered the opportunity to review the Advanced Behavioral Centers of DuPage HIPAA Privacy Notice.

_____◯ I would like to have a copy of this office's HIPAA Privacy Notice.

_____◯ I would not like to have a copy of this office's HIPAA Privacy Notice.

_____◉ I refuse to sign because: _____.

Print Patient Name: _____ Date: _____.

Patient Signature: _____ Date: _____.

Parent or Guardian Signature: _____ Date: _____.

Witness By: (Staff Name): _____ Date: _____.