Neurofeedback Clinic of Northern Colorado
4115 Boardwalk Drive, Ste 100
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P970-493-4580

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HIPPA PRIVACY RIGHTS

I hereby acknowledge that I have received a copy of the provider/psychotherapist **Notice of HIPAA Privacy Rights**. I further agree to read this **Notice of HIPAA Privacy Rights**. I will talk with my therapist if I have any concerns.

_____ I **WOULD** like a copy of this disclosure for my records.

_____ I **DO NOT** want a copy of this disclosure for my records.

_____
Name of client

_____ _____
Signature of client or guardian of minor child Date

_____ _____
Printed name of guardian Relationship

_____ _____
Signature of therapist Date