

HUDSPETH REGIONAL CENTER

Acknowledgment of Receipt of Notice of Privacy Practices

Date that Notice of Privacy Practices and Acknowledgment of Receipt of Notice were sent or given to Individual Client/Patient/Authorized Representative: _____

Name of Individual Client/Patient: _____

Case Number (if applicable): _____

I acknowledge that I have received the **Notice of Privacy Practices for Hudspeth Regional Center**, effective April 14, 2003.

Signature of Individual Client/Patient or Authorized Personal Representative

Date

Please return this form to:

Hudspeth Regional Center
Diagnostic Services
P.O. Box 127-B
Whitfield, MS 39193