

The Office of
Mason L. Kelly, LCSW
8553 S. Stony Island Ave., FL 1
Chicago, Illinois 60617
(773) 972-3577

**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 Mason L. Kelly's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Mason L. Kelly at (773) 972-3577.

Signature of Client **Date**

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

* 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.).

Client Refuses to Acknowledge Receipt:

Mason L. Kelly, LCSW **Date**