COUNSELING, HEALTH & WELLNESS CENTER
OVERLOOK SOUTH
(973)-720-2360 · (973)-720-2257 · FAX: (973)-720-2632
300 POMPTON ROAD · WAYNE, NEW JERSEY 07470-2103 · WWW.WPUNJ.EDU

Acknowledgement of Receipt of Notice of Privacy Practices

My signature below acknowledges that I have had the chance to review the Notice of Privacy Practices and had the opportunity to ask any questions I have regarding the information in the notice.

I understand that I may have a printed copy of this document if I so wish and may ask questions about its content at any point during my treatment at the Counseling, Health, and Wellness Center.

Student's Name ____ **Student ID# 855**________________
(Please Print)

Student's Signature ____ **Date** _______________

Parent/Guardian's Signature ____ ***Date*** _______________
(Required only if the student is 17 years old or younger)

FOR OFFICE USE ONLY

Witness Signature ____ **Date:** ___________

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign
_____ Communications barriers prohibited obtaining the acknowledgement.
_____ An emergency situation prevented us from obtaining acknowledgement
_____ Other (Please Specify) ____

Name/Signature of Office Staff: ____