

**James Madison University**  
**Occupational Therapy Clinical Education Services**  
Phone: 540-568-4980 Fax: 540-568-2645

**Mailing Address:**

755 Martin Luther King Jr. Way, MSC 9022  
Harrisonburg, VA 22801

**Physical Address:**

131 W. Grace St., Rm 1100  
Harrisonburg, VA 22807

**Documentation of Receipt of the Notice of Privacy Practices**

I \_\_\_\_\_ am signing this form for: \_\_\_\_\_  
Full printer name of consenting person Full printed name of client

\_\_\_\_\_  
Client's Date of Birth

\_\_\_\_\_  
Client's Full Address

My relationship to the client is:  Self  Parent  Power of Attorney  
 Guardian  Other legally authorized representative

I acknowledge that I have received the Notice of Privacy Practices from the Occupational Therapy Clinical Education Services at James Madison University.

\_\_\_\_\_  
Signature of Consenting Person or Parent/Legal Guardian Date

\_\_\_\_\_  
Signature of Adult Witness Date

Note: A more detailed documentation regarding your right to privacy is available upon request.