

**Benjamin Meyer, LCSW**  
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I (we)\_\_\_\_\_ fully acknowledge that I (we) have received, read, and und understood all and any information pertaining to the Health Information Portability and Privacy Act as provided to me by Benjamin Meyer, LCSW.

\_\_\_\_\_  
Client(s)

\_\_\_\_\_  
Benjamin Meyer, LCSW

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date