**Notice of Privacy Practices**
**Receipt and Acknowledgement of Notice**

**Patient/ Client Name:** _____

**DOB:** _____

I hereby acknowledge that I have received and have been given the opportunity to read a copy of Diana O'Brien, LCSW, Med's Notice of Privacy Practices. I understand that if I have any questions regarding this Notice or my privacy rights, I can contact Diana O'Brien at 703-930-5498, of the Office of Civil Rights.

_____ _____
**Signature or Patient/Client** **Date**

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

_____

*If you are signing as a personal representative or an individual, please describe your legal authority to act for this individual (ie. Power or Attorney, Healthcare Surrogate, etc.)

**Patient/ Client Refuses to Acknowledge Receipt:**

_____ _____
**Signature of Clinician** **Date**