NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGMENT OF NOTICE

Patient/ Client Name: _____

Date of Birth: _____

I hereby acknowledge that I have been given an opportunity to read a copy of Therapist Dina Lomas, LCSW Notice of Privacy Practices. I understand that if I have questions regarding the notice or my privacy rights, I can contact Dina Lomas, LCSW.

_____ I am requesting that a copy be given to me.

_____ I am declining a copy.

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian, or Personal Representative*

*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.)

_____ Patient/Client Refuses to acknowledge Privacy Practices.