Elizabeth H. Pilson, LCSW-C

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below, I acknowledge that I received a copy of the Notice of Privacy Practices from Elizabeth H. Pilson, LCSW-C, and I consent to the policies regarding use and disclosure of my Protected Health Information.

_____
Printed Name of Patient

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Printed Name of Legal Guardian Date

OFFICE USE ONLY

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

_____ Individual refused to sign

_____ Communication barrier prohibited obtaining the acknowledgment

_____ An emergency situation prevented us from obtaining the acknowledgment

_____ Other (Please specify)

_____

_____

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This form will be retained in your medical record