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NOTICE OF PRIVACY PRACTICES
RECEIPT AND ACKNOWLEDGMENT OF NOTICE

Patient/Client Name: ____
DOB: ______________________________ SSN: __________________________

I hereby acknowledge that I have received and have been given an opportunity to read a copy of the Privacy Practices. I understand that if I have any questions regarding I can talk to Dr. Galaszewski about it.

____
Signature of Patient/Client

____
Signature of Parent, Guardian, or
Personal Representative*

____
Date

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* 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 Receipt: