NOTICE OF PRIVACY PRACTICES

Receipt and Acknowledgment of Notice

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

As a patient, I understand that I have certain rights and responsibilities as it relates to my privacy and healthcare. I understand it is important to know those rights and responsibilities.

I hereby acknowledge that I have received and have been given an opportunity to read a copy of "Notice of Privacy Practices" of the Offices of Richard Stout, M.S., L.M.H.C. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Richard Stout, M.S., L.M.H.C., at P.O. Box 953443, Lake Mary, Florida 32746

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Signature of Patient/Client ***Date***

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Signature or 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**:

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Signature of Staff Member ***Date***

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