ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ____, acknowledge that I have received a copy of Maura D. Sullivan Psy.D.'s Notice of Privacy Practices.

This Notice describes how Maura D. Sullivan Psy.D. may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

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Signature of Patient or Representative   Date

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Relationship to Patient