Donnie R. Gayfield, LCSW, MSW, BA

Notice of Privacy Practices
Receipt and Acknowledgement of Notice

Patient/Client Name:_____

DOB:_____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Donnie R. Gayfield Psychotherapist's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights I can contact [Insert Name of Privacy Officer and Contact Information].

_____

Signature of Patient/Client **Date**

_____

Signature of Parent, Guardian or Personal Representative* **Date**

_____

*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:**

_____

Signature of Psychotherapist **Date**