**ACKNOWLEDGEMENT OF RECEIPT**

**2013 NOTICE OF PRIVACY PRACTICES**

By signing this form, I acknowledge being given the Notice of Privacy Policies by Dr. Lisa Livshin Ed.D., Licensed Psychologist. This notice provides detailed information about how she may use and disclose my protected health information, what my rights are regarding my protected health information, and how I can file a complaint about these privacy practices.

Patient Name_____ Date of Birth _____

Signature of Patient, Guardian, or Legal Representative

_____ Date _____

Name of Guardian or Legal Representative _____

Relationship to patient _____