

NOTICE OF PRIVACY PRACTICES
RECEIPT AND ACKNOWLEDGEMENT OF NOTICE

By signing this form, you acknowledge receipt of the Notice of Privacy Practices from Alison Wittenberg, APRN. The Notice of Privacy Practices provides information about the potential use and disclosure of your protected health information. You are encouraged to review it carefully. The Notice of Privacy Practices is subject to change. If the Notice is changed, you may obtain a revised copy by visiting the U.S. Department of Health and Human Services website at www.hhs.gov or by request from your provider.

I acknowledge that I have received and have been given the opportunity to read the Notice of Privacy Practices. I understand that if I have further questions regarding the Notice of Privacy Practices or my privacy rights I can speak with my provider.

Signature of Patient/Client

Date

Signature of Parent/Guardian (under 18 y.o.)

Date

Print Name

_____ Patient Refuses to Acknowledge Receipt

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