



SHONDA *moralis*

WWW.SHONDAMORALIS.NET
SHONDA@SHONDAMORALIS.NET

**Notice of Privacy Practices
Receipt and Acknowledgment of Notice**

Patient/Client Name: _____

DOB: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Shonda Moralis' Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Shonda Moralis, LCSW.

Signature of Patient/Client

Date

Signature or 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 Staff Member

Date