PSYCHIATRIC ASSOCIATES, P.A.

MICHAS, VALENTINE & GILL

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of **Psychiatric Associates, P.A., Michas, Valentine *&* Gill,** "NOTICE OF PRIVACY PRACTICES."

As required by the Privacy Regulations, _____from
Name of Staff Member
Psychiatric Associates, P.A. Michas, Valentine & Gill, has explained the "NOTICE OF PRIVACY PRACTICES" to my satisfaction.

As required by the Privacy Regulations, I am aware that **Psychiatric Associates, P.A., Michas, Valentine & Gill,** has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

Requests:

☐ I wish to file a "Request for Restriction" of my Protected Health Information.

☐ I wish to file a "Request for Alternative Communications" of my Protected Health Information.

☐ I wish to object to the following in the "Notice of Privacy Practices":
_____
_____

I understand that this office is not required to honor any changes to the "Notice of Privacy Practices."

_____ _____
Patients Name Date

_____
Patient Signature

(OFFICE USE ONLY)

Signed form received by: _____ Date: _____

Good faith effort to obtain receipt: (Describe) _____
_____
_____

