

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
CENTER FOR ANXIETY & CHRONIC WORRY

I HEREBY ACKNOWLEDGEMENT THAT I HAVE RECEIVED A COPY OF THIS MENTAL HEALTH PRACTICE'S **NOTICE OF PRIVACY PRACTICES**. I FURTHER ACKNOWLEDGE THAT I HAVE BEEN OFFERED A COPY THIS **NOTICE OF PRIVACY PRACTICES**.

PRINTED NAME: _____

SIGNATURE: _____

DATE: _____

TELEPHONE: _____

IF NOT SIGNED BY THE PATIENT, PLEASE INDICATE:

RELATIONSHIP:

- PARENT OR GUARDIAN OF MINOR PATIENT
- BENEFICIARY OR PERSONAL REPRESENTATIVE OF DECEASED PATIENT

PRINTED NAME OF PATIENT:
