Chuck Stannard,MSW
2014 Delta Blvd.
Tallahassee,FL 32303

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client Name:____
DOB: ____
SSN:____

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

____
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**

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