Associates for Psychiatric Services, P.C.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form I acknowledge that I have received the *Notice of Privacy Practices* from Associates for Psychiatric Services, P.C.

I understand that the *Notice of Privacy Practices* describes the allowed uses and disclosures of my protected health information by Associates for Psychiatric Services, P.C. and the rights I have regarding that information.

I have the right to review the *Notice of Privacy Practices* prior to signing this Acknowledgement and have the right to request a paper copy of the *Notice*.

I also understand that Associates for Psychiatric Services, P.C. has the right to change its *Notice of Privacy Practices* from time to time. The *Notice* will be posted within the office of Associates for Psychiatric Services, P.C. and paper copies will be available at the registration desk. The *Notice* is also posted electronically on the website of Associates for Psychiatric Services, P.C. at: www.afpssc.com

Patient Name: _____

Date: _____

Signature of Patient or Legal Representation:

_____

For Legal Representative, State Relationship to the Patient:

_____

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