

Gerald W. Greenfield, Ph.D.

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Individuals, Couples,
and Group Psychotherapy

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices of Gerald W. Greenfield, Ph.D. I understand that this document provides an explanation of confidentiality and privacy as well as an explanation of the ways my health information may be used and/or disclosed by Dr. Greenfield. It also explains my rights with respect to my health information.

I have had the opportunity to review this document and to discuss any concerns or questions I may have regarding the privacy of my health information.

(Patient Name) (Date of Birth)

(Patient Signature) (Today's Date)

(If two patients:)

(Additional Patient Name) (Date of Birth)

(Additional Patient Signature) (Today's Date)

(If patient is a minor:)

(Parent or Legal Guardian Signature) (Specify Relationship to Patient)

(Provider Signature) (Date)