Peggy Albano
MA, LMHC, CST, C-SAT, GC-C

2033 Wood Street, Suite 115
SARASOTA, FL 34237
PHONE:(941)914-5553
FAX: (941) 296-1508
www.peggyalbanotherapy.com

Notice of Privacy Practices
Receipt and Acknowledgement of Notice

Patient/Client Name: _____ DOB:_____

Patient/Client Name: _____ DOB:_____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of *Peggy Albano Therapy LLC* Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the Secretary of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201, or by calling (202) 619-0257.

_____
Signature of Patient/Client Date

_____
Signature of Patient/Client Date

_____
Signature of 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

_____
Clinician Signature Date