



Notice of Privacy Practices Receipt and Acknowledgement of Notice

Client Name: _____

Date of Birth (DOB): _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Stacey Curl, MA, LMHC Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Stacey Curl, MA, LMHC, PO Box 3144, Lacey, WA 98509, PHONE: 360-402-7674.

Signature of Client Date

Signature of 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.).

Client Refuses to Acknowledge Receipt:

Signature of Stacey Curl, MA, LMHC Date