Marcia S. Gibson PsyD & Associates, P.C.

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

This Notice describes how Medical Information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Client Name: _____

Date of Birth: _____ / _____ / _____

I hereby Acknowledge that I have received and have been given an opportunity to read a copy of Marcia S. Gibson PsyD & Associates, P. C. Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Marcia S. Gibson PsyD & Associates, P. C. by phone at (630) 759-4000.

_____ _____

Client Signature Date

_____ _____

Parent, Guardian or Personal Representative Signature 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 Witness Date