Hope Panara, MA, LPA
Licensed Psychological Associate

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HIPAA Privacy Practices Receipt and Acknowledgment of Notice

Patient Name: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of the HIPAA Notification of Privacy Practices. I understand that if I have any questions regarding this notice or my privacy rights, I may contact Hope Panara at (919) 307-7889.

_____ _____

Signature of Patient or Legal Representative* Date

* If you are signing on behalf of someone, please describe your legal authority to act for this individual (i.e. parent, guardian, legal custodian, power of attorney, healthcare surrogate).