Heather K. Mazarakos MSW LCSW
HKM Psychotherapy Associates LLC

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client Name: _____

DOB: _____ SSN:_____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of
Heather K. Mazarakos MSW LCSW HKM
Psychotherapy Associates LLC
Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Heather K. Mazarakos MSW LCSW at 161 Cook Hill Rd Wallingford CT 06492 (203) 253-9708 or email heather@hkmpsychotherapy.com

_____

Signature of Patient/Client Date

_____

Signature or 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:

_____

Signature of Staff Member Date

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