John Gallagher, LMHC
1850 Lee Road
Suite #323
Winter Park, FL 32789
(407) 579-2070

Receipt and Acknowledgment of Notice of Health Insurance Portability and Accountability Act (HIPAA)

Client Name: _____

DOB: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Notice of Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, for John Gallagher, LMHC. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact John Gallagher, LMHC.

Sign: _____ Date: _____
Signature of client (or parent/guardian or Personal Representative*)
*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.):

_____
John Gallagher, LMHC

Date: _____