Robyn Coughlin, LCSW

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 Robyn Coughlin, LCSW's Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can discuss this with Ms. Coughlin.

_____
Signature of Patient/Client

_____
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:

_____

Therapist Date