**LEE FOX MARLEY, LCSW**

15303 Texas Street

Austin, Texas  78734

Ph (512) 913-1984

Fax (888) 242-2823

**NOTICE OF PRIVACY PRACTICE**

**RECEIPT AND ACKNOWLEDGEMENT OF NOTICE**

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SOCIAL SECURITY NUMBER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I acknowledge that I have received and have been given an opportunity to read a copy of Lee Fox Marley, LCSW, Notice of Privacy Practice.

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Signature of Client                                                                                Date

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Signature of Parent, Guardian, or Personal Representative        Date

I hereby acknowledge that I consent to the Privacy Practice Policy of Lee Fox Marley, LCSW.  I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Lee Fox Marley, LCSW, and/or contact the Secretary of the Department of Health and Human Services at: 200 Independence Avenue, S.W. Washington, DC 20201 or by calling (202) 619-0257.

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Signature of Client                                                                                Date

\_\_\_\_\_\_\_\_\_\_\_\_\_Client refuses to acknowledge consent

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Signature of Psychotherapist                                                              Date