LEE FOX MARLEY, LCSW
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Ph (512) 913-1984
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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.

_____

Signature of Client Date

_____

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.

_____

Signature of Client Date

_____Client refuses to acknowledge consent

_____

Signature of Psychotherapist Date