Gerald W. Greenfield, Ph.D.

Licensed Psychologist

PO Box 259595
Madison, WI 53725-9595
(608) 271-8799

Individuals, Couples,
and Group Psychotherapy

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices of Gerald W. Greenfield, Ph.D. I understand that this document provides an explanation of confidentiality and privacy as well as an explanation of the ways my health information may be used and/or disclosed by Dr. Greenfield. It also explains my rights with respect to my health information.

I have had the opportunity to review this document and to discuss any concerns or questions I may have regarding the privacy of my health information.

______________________________ ______________
(Patient Name) (Date of Birth)

______________________________ ______________
(Patient Signature) (Today's Date)

(If two patients:)

______________________________ ______________
(Additional Patient Name) (Date of Birth)

______________________________ ______________
(Additional Patient Signature) (Today's Date)

(If patient is a minor:)

______________________________ ______________________________
(Parent or Legal Guardian Signature) (Specify Relationship to Patient)

______________________________ ______________
(Provider Signature) (Date)

Form: Privacy Notice Receipt 220322