

BARBARA KEYWORTH, ACSW, LCSW
4601 Lake Boone Trail, Suite 2C
Raleigh, NC 27607

**Notice of Privacy Practices
Receipt and Acknowledgment of Notice**

Patient/Client Name: _____

DOB: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Barbara Keyworth's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Barbara Keyworth, LCSW

Signature of Patient/Client **Date**

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:

Signature of Staff Member **Date**