ROBERT ROMANO, LCSW, LLC

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 **ROBERT ROMANO, LCSW, LLC's** notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact: **Robert Romano, LCSW** at **30 Old Kings Highway South, Darien, CT 06820; or via phone at: 203.654.9094.**

_____

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**