Allyson Awasthi, MS, LMHC
Licensed Mental Health Counselor #MH17960
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Notice of Privacy Practices
Acknowledgment of Notice

Patient/Client Name: _____

Date of Birth: _____

I hereby acknowledge I have received and been given an opportunity to read a copy of Allyson Awasthi's Notice of Privacy Practices. I understand that if I have any questions regarding the notice I can contact Allyson Awasthi LMHC. at (561) 427-3660 or by email at info@awasthicounseling.com.

_____ _____
Signature of Patient/Client Date

_____ _____
Signature of Parent/Guardian or Personal Representative Date

(If you are signing as a guardian or legal representative please provide accompanying legal documentation of legal authority)

Patient refuses to acknowledge receipt

_____ _____

_____ _____
Signature of Witness Date