Abigail Burd, LCSW
California License: LCS26867

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 Abigail Burd's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact my therapist. If after discussing my concerns, I feel my therapist has not settled my issue with privacy, I may contact the California Board of Behavioral Sciences at http://www.bbs.ca.gov/consumer/complaint_info.shtml, or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257.

____
Signature of Patient/Client **Date**

____
Signature or Parent, Guardian or Personal Representative · **Date**

* If you are signing for an individual, please describe your legal authority to act for this individual (parent, power of attorney, healthcare surrogate, etc.).

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