

Emily
Markowitz

LMSW, LCSW

LICENSED CLINICAL SOCIAL WORKER

Emily Markowitz, LMSW, LCSW
Licensed Clinical Social Worker

Receipt and Acknowledgment of Notice of Privacy Practices

Patient/Client Name: _____

DOB: _____

SSN: _____

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

Signature of Patient/Client Date

Signature of 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