THOMAS L. FUSCO
LICENSED CLINICAL PROFESSIONAL COUNSELOR

Acknowledgment of Recceipt of Privacy Practices

Patient Name:_____ **DOB:** _____

Maiden or other Name (if applicable)**:** _____

PLEASE CHECK ONE OF THE BELOW STATEMENTS THEN SIGN BELOW

I acknowledge that I have received a copy of the Notice of Privacy Practice of Thomas L. Fusco, LCPC

I have read but declined a copy of the Notice of Privacy Practice of Thomas L Fusco, LCOC

Signature (patient or authorized representative): _____

Date: _____

Consent to the release of Protected Health Care Information for Treatment, Payment and Health Care Operations

I consent to the use of my protected health information by Thomas L. Fusco, LCPC for the purpose of diagnosing and providing treatment to me, obtaining payment for my health care bills or to conduct health care operations.

I have the right to revoke this consent, in writing, at any time to the extent Thomas L. Fusco, LCPC has taken action in reliance on this consent.

Signature (patient or authorized representative): _____

Date: _____

Relationship/Authority (if signed by someone other than the patient)