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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (NOPP)

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices (NOPP) and have therefore been advised of how health information about me may be used and disclosed by Linda M. Carroll, Ph.D., CCC/SLP FASHA, and how I may obtain access to and control this information.

_____ _____

Patient's Name (Print) Date

_____ _____

Signature of Patient or Personal Representative Date

_____

Description of Personal Representative's Authority

Print Name: _____ Date: _____