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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____

I have been given a copy of Mandy Menzer, Psy.D.'s Notice of Privacy Practices ("Notice"), which describes how my health information is used and shared. I understand that Dr. Menzer has the right to change this Notice at any time. I may obtain a current copy by contacting the practice's Privacy Officer, or by visiting Dr. Menzer's website at: www.drmenzer.com

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices.

Signature of Patient or Personal Representative

Date

Print Name

Personal Representative's Title
(e.g. guardian, executor of estate, health care power of attorney)

For practice use only: Complete this section if you were unable to obtain a signature.

If patient or personal representative is unable or unwilling to sign this Acknowledgement, or the Acknowledgement is not signed for any other reason, state the reason:

Describe the steps taken to obtain the patient's or personal representative's signature on the Acknowledgement:

Completed by:

Signature of Practice Representative

Date

Printed Name