Tarazi Neuropsychology Services LLC
Reem Tarazi, PhD, ABPP
940 E. Haverford Rd.,Ste. 202
Bryn Mawr, PA 19010
267-217-3003; info@tarazineuropsych.com

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ Patient DOB:_____

I acknowledge receipt of the *Notice of Privacy Practices* for Tarazi Neuropsychology Services LLC.

I understand that during treatment/evaluation with Dr. Tarazi, she will be collecting "protected health information" (PHI) about me/my child and my family as described in the *Notice of Privacy Practices*. This information is used for the purposes of treatment, evaluation, payment, or health operations as described in the *Notice or Privacy Practices*.

I have the right to withdraw my consent to use or share protected health information but I understand that Dr. Tarazi may have already used or shared some of it, and cannot change that.

By signing this consent form, I acknowledge that I understand and agree to the above.

_____
Signature of Parent/Conservator/Guardian/Legal Representative or Patient (if 18 or older)

_____
Printed Name of Parent/Conservator/Guardian/Legal Representative or Patient (if 18 or older)

_____
Relationship to Patient

_____
Date