

**Maren W. Deaver, LCSW**

**847/840-9719**

**Receipt of Notice of Privacy Practices**

By signing this form, you acknowledge that you have received the Notice of Privacy Practices from Maren W. Deaver, LCSW. This notice provides information about the ways in which I may use and disclose your protected health information. I encourage you to read it in full.

The Notice of Privacy Practices is subject to change. You may ask me at any time for a copy of the current notice, either in person or by contacting me at the phone number above.

I acknowledge that I have received the Notice of Privacy Practices.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

If no signature is obtained above, describe the good faith efforts made to obtain the individual's acknowledgement and the reasons why it was not obtained.

\_\_\_\_\_  
Therapist's Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date