Healing Psychotherapy Practices of Georgia, LLC
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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

_____ I understand that at my request I have the right to view or have a copy of the privacy practices of Healing Psychotherapy Practices of Georgia, LLC. This will outline how my protected health information can be used and shared and what I can do if I have problems or questions while receiving services from Healing Psychotherapy Practices of Georgia, LLC.

Signature:_____

Print Name:_____

Date:_____