

SERVICES OF ROBERT D. GREGORY, PH.D.

**ACKNOWLEDGEMENT TO RECEIPT OF NOTICE OF PRIVACY
PRACTICE AND PSYCHOLOGIST-PATIENT SERVICES
INFORMATION FORMS**

This form, when completed by you, acknowledges that you have received a copy of the Notice of Privacy Practices and the Psychologist-Patient Services Information for Robert D. Gregory, Ph.D.

I, _____, acknowledge that I have received a
(Patient or Patient's Legal Guardian)

copy of the Notice of Privacy Practices and Psychologist-Patient Services
Information Forms for Robert D. Gregory, Ph.D. on this date _____.
(month, day, year)

(Signature of Patient or Patient's Legal Guardian)

(Date)

PATIENT'S NAME: _____

AUTHORITY TO ACT FOR PATIENT: _____
(example - parent or legal guardian)