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Patient Name: _____

Parent Name: _____

Address: _____

Notice of Privacy Practices Acknowledgment of Receipt Form

Your signature below indicates that you have received a copy of the Notice of Privacy Practices. If you have any questions about the Notice of Privacy Practices, please ask Dr. McGarrahan.

Patient Signature

Date

OR

Parent Signature

Date

OR

Legal Guardian Signature

Date

Legal Guardian Relationship to Patient