DORIS M. DOMINGUEZ, MSW, LCSW
LICENSED PSYCHOTHERAPIST
9010 SW 137 AVENUE
SUITE 236
MIAMI, FL 33186
(305) 772-9681

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of the above named practice's Notice of Privacy Practices.

_____	_____
Client's Name (print)	Date
_____	_____
Client's Signature	Date
_____	_____
Parent or Guardian Name (print)	Date
_____	_____
Parent or Guardian Signature	Date

_____ (Initial) I authorize you to leave voice mail and text messages on my home answering machine or cell phone in regard to appointments and answers to my medical questions when in the judgment of the office this would be in my best interest.

_____ (Initial) I authorize you to leave messages with other family members or friends that answer my home phone when in the judgment of the office this would be in my best interest.

_____ (Initial) I authorize you to leave messages at my place of employment for me to return your calls.

_____ (Initial) I authorize you to E-mail messages in regard to appointments and answers to my medical questions to this E-mail address _____.