NICOLE HRANIOTIS, MD
Child, Adolescent & Adult Psychiatry

SIGNED RECEIPT OF HIPPA NOTICE OF PRIVACY PRACTICES

I/we (print name)_____have reviewed and/or received a copy (if requested, paper copy) of the Notice of Privacy Practices for Nicole Hraniotis, M.D., LLC. By signing this document, I understand and am in agreement to my privacy rights in regard to treatment from Nicole Hraniotis, M.D., LLC.

_____ _____

Patient Signature Date

_____ _____

Parent, Legal Gardian, or Conservator Signature Date