

Anthony Iacovelli, Ph.D.  
Psychotherapy, Evaluation, and Behavioral Health Services

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**RECEIPT OF NOTICE OF  
PRIVACY PRACTICES ACKNOWLEDGMENT FORM**

I hereby acknowledge that on \_\_\_\_\_ I received the Notice of Privacy Practices from Anthony Iacovelli, Ph.D., which sets forth the ways in which my personal health information may be used or disclosed by Anthony Iacovelli, Ph.D., and outlines my rights with respect to such information.

\_\_\_\_\_  
Patient's signature

\_\_\_\_\_  
Date