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ATTESTATION FORM

I have read the Notice Regarding Patient Records Privacy: Policies and Procedures document. My signature below indicates that I agree to its terms. I was given the opportunity to discuss this agreement and ask any questions to clarify information. I understand that I will be provided with a copy of this document upon request.

Printed Name	 Date	Signature	
My signature below in	ndicates that I do not agre	ee to its terms.	
Signature			
My signature below in	ndicates that I am not able	e to sign as I do not und	lerstand its terms.
 Signature		Witness	Date
indicates that I agree	to its terms. I was given t ify information. I unders	he opportunity to discu	nent. My signature belown ass this agreement and ask vided with a copy of this
Printed Name	Date	Signature	
My signature below in	ndicates that I do not agre	ee to its terms.	
 Signature			
My signature below in	ndicates that I am not able	e to sign as I do not und	lerstand its terms.
Signature		Witness	 Date