Valerie R. Wilson, Ph.D.
255 South 17th Street
Suite 1300
Philadelphia, PA 19103
Tel: 267-634-1719

My signature below acknowledges that I have received a copy of **Notice of Privacy Practices** from Dr. Valerie Wilson.

_____
Name of Client (print)

_____ _____
Client's Signature Date

_____ _____
Signature of authorized representative of this practice Date

This form is retained as part of client's medical record.