

**Marianne O'Leary, Ph.D.**  
*Licensed Psychologist*

3555 Saint John's Lane, Suite F  
Ellicott City, Maryland 21042

410-465-5520  
Fax: 410-480-9575

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Date: \_\_\_\_\_

I acknowledge that I have received a copy of the Maryland Notice of Privacy Rights as outlined under the Health Insurance Portability and Accountability Act (HIPAA).

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Signature

\_\_\_\_\_  
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