

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* that I have given to you. My *Notice of Privacy Practices* provides information about how I may use and disclose your protected health information (PHI). I encourage you to read it in full.

My *Notice of Privacy Practices* is subject to change. If I change my notice, you may obtain a copy of the revised notice from me by contacting me at 510-797-9322.

If you have any questions about my *Notice of Privacy Practices*, please contact me at:

Patricia Stryd
Licensed Marriage and Family Therapist
4500 Thornton Avenue
Fremont, California
510-797-9322

I acknowledge receipt of the *Notice of Privacy Practices* of Patricia Stryd.

Signature: _____ Date: _____
(patient/parent/conservator/guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I made good faith attempts to obtain my patients acknowledgement of his or her receipt of my *Notice of Privacy Practices*, including: _____

However, because of _____

I was unable to obtain my patient's acknowledgment.

Signature of Provider: _____ Date: _____