

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

By signing this form, you acknowledge receipt of this *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. 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: (805) 886-5538.

If you have any questions about my *Notice of Privacy Practices*, please contact me at (805) 886-5538.

I acknowledge receipt of the *Notice of Privacy Practices* of Susan Farber, M.A., MFT.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(patient/parent/conservator/guardian)

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**INABILITY TO OBTAIN ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I made good faith attempts to obtain my patients acknowledgment of his or her receipt of my *Notice of Privacy Practices* by\_\_\_\_\_. However, because of \_\_\_\_\_, I was unable to obtain my patient’s acknowledgment.

Signature of Provider: \_\_\_\_\_ Date: \_\_\_\_\_