

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. 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 by contacting April Scott, LCSW, at 925-998-9537.

If you have any questions about Notice of Privacy Practice or HIPAA, please contact me at: 925-998-9537.

I acknowledge receipt of the Notice of Privacy Practice/HIPAA document.

Signature: \_\_\_\_\_

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

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INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE  
OF PRIVACY PRACTICES

I made good faith attempts to obtain my patient's/client's acknowledgement of his or her receipt of my **Notice of Privacy Practices**, including \_\_\_\_\_.  
However, because of \_\_\_\_\_, I was  
Unable to obtain my patient's/client's acknowledgement.

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

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