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 from me by contacting me at 925-998-9537.

If you have any questions about my **Notice of Privacy Practices**, please contact me at: **555 Peters Ave., Suite 260-B, Pleasanton, Ca. 94566, 925-998-9537**.

I acknowledge receipt of the **Notice of Privacy Practices** of April Scott, LCSW.

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

INABLILITY TO OBTAIN ACKNOWEDGEMENT 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:_____