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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 *714-390-8189*.

If you have any questions about my *Notice of Privacy Practices,* please contact me at: *714-390-8189*.

I acknowledge receipt of the *Notice of Privacy Practices* of *Lisa Maurel, MFT*

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 [describe good faith attempts]. However, because of [__________________] I was unable to obtain my patient's acknowledgement.

Signature of Provider: __________________________
Date: _________________

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