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)

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:_____