

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 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 Ilana Wasserman 714-856-8333.

If you have any questions about my *Notice of Privacy Practices*, please contact me at Ilana Wasserman 714-856-8333.

I acknowledge receipt of the *Notice of Privacy Practices*.

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

INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I made good faith attempt to obtain my patients acknowledgement of their receipt of my Notice of Privacy Practices, including (describe good faith attempts). However, because of *(insert reasons why acknowledgement was not obtained)* I was unable to obtain my patient's acknowledgement.

Signature of Provider: _____ Date: _____