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, I will notify you in writing.

If you have any questions about my *Notice of Privacy Practices,* please contact me, **Eileen Drapiza-Dornan, LMFT at (510) 859-4362**.

I acknowledge receipt of the *Notice of Privacy Practices* of Eileen Drapiza-Dornan, LMFT.

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: _____