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 Ariella Goodwine Fisher, MFT (650) 342-6980.

If you have any questions about my Notice of Privacy Practices, please contact me at:

1710 So. Amphlett Blvd. #107, San Mateo, CA 94402 (650) 342-6980.

I acknowledge receipt of the Notice of Privacy Practices of the office of Ariella Goodwine, 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 [ ].
However,because of [ ]
I was unable to obtain my patient's acknowledgement.

Signature of Provider: _____
Date:_____