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 (831) 824-4540.

If you have any questions about my *Notice of Privacy Practices*, please contact me at: 831.824-4540.

I acknowledge receipt of the *Notice of Privacy Practices* of Ellis McCauley, MS, 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:

However, because of:

I was unable to obtain my patient's acknowledgement.
Signature of Provider: _____ Date: _____