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 1-408-249-0014.

If you have any questions about my *Notice of Privacy Practices,* please contact me at: 1588 Homestead Avenue, Santa Clara, CA 95050 or 1-408-249-0014.

I acknowledge receipt of the *Notice of Privacy Practices* of *Daniel R. Davis, 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:

_____ _____