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 (818) 426-2495.

If you have any questions about my *Notice of Privacy Practices,* please contact me at: 15233 Ventura Blvd., Suite 1208. Sherman Oaks, CA 91403.

I acknowledge receipt of the *NOTICE OF PRIVACY PRACTICES* of *Anita Avedian, 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: _____