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 (951) 296-9460.

If you have any questions about my *Notice of Privacy Practices*, please contact me at 29291 Providence Road, Temecula, CA 92591, phone (951) 296-9460.

I acknowledge receipt of the *Notice of Privacy Practices* of Cathryn L. Leff, LMFT.

Signature:______________________________ Date:_______________________
(patient/parent/conservator/guardian)

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INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient did receive the *Notice of Privacy Practices*, but did not sign this Acknowledgement of Receipt because:

[ ] Patient left office before Acknowledgement could be signed.
[ ] Patient did not wish to sign this form.
[ ] Patient cannot sign this form because____________________________________.

[ ] Patient did not receive the *Notice of Privacy Practices* because:
[ ] Patient required emergency treatment.
[ ] Patient declined the Notice and signing this Acknowledgement.

Name:____
(Printed name of provider)

Signed:____________________________________ Date:____________________
(Signature of provider)