**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 707-743-4082.

If you have any questions about my *Notice of Privacy Practices,* please contact me at: [wendy@calomiriscounseling.com](mailto:wendy@calomiriscounseling.com) or call me at 707-743-4082.

I acknowledge receipt of the *Notice of Privacy Practices* of Calomiris Counseling.

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 [describe good faith attempts]. However, because of [*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*] I was unable to obtain my patient’s acknowledgement.

Signature of Provider: Date:

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