ACKNOWLEDGMENT 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 by request.

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

2928 San Marcos Avenue
P.O. Box 863
Los Olivos, CA 93441
805.757.7783

1610 Oak Street, Suite 203
Solvang, CA 93463
Phone # 805-697-7756

I acknowledge receipt of the *Notice of Privacy Practices* of Beverly C. Taylor and/or Family Counseling & Trauma Healing Center, Inc.

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

Date:______________________

INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I made good faith attempts to obtain my patient's acknowledgment of his or her receipt of my Notice of Privacy Practices. However, due to____
______________ I was unable to obtain my patient's acknowledgement.

Signature of Provider:________________________

Date:_______________________

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