PSYCHOTHERAPY STRESS-RELIEF SERVICES

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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 [insert telephone number].

If you have any questions about my Notice of Privacy Practices, please contact me at: [insert address and telephone number].

I acknowledge receipt of the Notice of Privacy Practices of [name of covered entity].

Signature: _____ Date: _____
(Client/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 [insert reasons why acknowledgement was not obtained] I was unable to obtain my patient's acknowledgement.

Signature of Provider: _____ Date: _____