

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 (559) 321-7916.

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

1702 E. Bullard Ave., Suite 102

Fresno, CA 93710

(559) 321-7916

I acknowledge receipt of the *Notice of Privacy Practices* of Mónica S. Reynoso, MS, LMFT, LPCC.

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. However, I was unable to obtain my patient's acknowledgement.

Signature of
Provider: _____ Date: _____