**ACKNOWLEDGEMENT OF RECIEPT 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: 530-300-4059.

If you have any questions about my *Notice of Privacy Practices*, please contact me at: 530-300-4059.

I acknowledge receipt of the *Notice of Privacy Practices* of Miki Hawkins, LMFT.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(client/parent/conservator/guardian)*

**INABILITY TO OBTAIN ACKNOWLEDGEMENTOFRECEIPT OF NOTICE**

**OF PRIVACY PRACTICES**

I made good faith attempts to obtain my clients 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 client’s acknowledgement.

Signature of Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_