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 760-687-9883.

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

1650 Linda Vista Drive Ste. 210
San Marcos, CA 92078
760-687-9883

I acknowledge receipt of the Notice of Privacy Practices of Mary L. Hill MFT.

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 patient's acknowledgment of his or her receipt of my Notice of Privacy Practices, including ____

____

____.

However, because of ____

____

____

I was unable to obtain my patient's acknowledgment.

Signature of Provider: ___________________________________ Date: _________________________

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