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 (858) 356 - 5839.
If you have any questions about my *Notice of Privacy Practices,* please contact me at:
11772 Sorrento Valley Rd. Suite 157 San Diego, CA 92121.

I acknowledge receipt of the *Notice of Privacy Practices* of Jacquelyn Schwartz, LMFT.

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 patients acknowledgement of his or her receipt of my Notice of Privacy Practices, including ________________________. However, because of ____
I was unable to obtain my patient's acknowledgement.

Signature of Provider: __________________________________

Date: ________________________

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