

**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 (PHI). 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 510-797-9322.

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

Patricia Stryd  
*Licensed Marriage and Family Therapist*  
4500 Thornton Avenue  
Fremont, California  
510-797-9322

I acknowledge receipt of the *Notice of Privacy Practices* of Patricia Stryd.

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*, including: \_\_\_\_\_  
\_\_\_\_\_

However, because of \_\_\_\_\_  
\_\_\_\_\_

I was unable to obtain my patient's acknowledgment.

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