



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 by contacting me at (760) 458-1600.

If you have any questions about my Notice of Privacy Practices, please contact me at jenniferhillcounseling.com or (760) 458-1600.

I acknowledge receipt of the Notice of Privacy Practices of Jennifer Hill, 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, including request at time of initial interview session. However, because of _____, I was unable to obtain my patient's acknowledgement.

Signature of Provider: _____

Date: _____