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 760-456-9350.

If you have any questions about my *Notice of Privacy Practices*, please contact me by mail at 1819 Avenida Flores, Encinitas, CA 92024, or by phone at 760-456-9350.

I acknowledge receipt of the *Notice of Privacy Practices* of Kristen Hornung.

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 acknowledgement.

Signature of Provider: ____________________________ Date: ___________