

**NOTICE OF PRIVACY PRACTICES**

Dr. Nadieh Kakar, LMFT

**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 you have any questions about my *Notice of Privacy Practices* or if I change my notice, you may obtain a copy of the revised notice from me by contacting me at 201 Sand Creek Road, Suite G-2, Brentwood, CA 94513; (925)567-4268

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

Client Signature **X** \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

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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 \_\_\_\_\_