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 (818) 623-7330.

If you have any questions about my Notice of Privacy Practices, please contact me at 23603 Park Sorrento Suite 100 Calabasas, CA (818)623-7330.

I acknowledge receipt of the Notice of Privacy Practices.

Signature: ____________________________________ 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. However, because of multiple attempts having failed I was unable to obtain my patient's acknowledgement.

Signature of Provider: _____________________________Date: _______________________