**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

By signing this form, you acknowledge receipt of the Notice of Privacy Practices that was provided 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 the Avedian Counseling Center at (818) 383-1399. If you have any questions about my Notice of Privacy Practices, please contact Anita Avedian at: 15233 Ventura Blvd., Suite 1208, Sherman Oaks, California 91403.

**I acknowledge receipt of the Notice of Privacy Practices of Anita Avedian, LMFT.**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_ (patient/parent/conservator/guardian)

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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

I was unable to obtain my patient’s acknowledgement.

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