# 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 the Avedian Counseling Center at (818) 426-2495.

If you have any questions about my *Notice of Privacy Practices,* please contact me at: 15233 Ventura Blvd., Suite 1208, Sherman Oaks, CA 91403 or by calling (818) 426-2495.

I acknowledge receipt of the *Notice of Privacy Practices* of *Avedian Counseling Center.*

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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I was unable to obtain my patient’s acknowledgement.

Signature of Provider: Date:

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