

NORTH STATE COUNSELING

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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 (530) 768-1188.

If you have any questions about my *Notice of Privacy Practices*, please contact me at: 3330 Churn Creek Rd, Ste. D4, Redding, CA 96002 (530) 768-1188.

I acknowledge receipt of the *Notice of Privacy Practices* (4 pages) of North State Counseling.

Client Name: _____

Name of Representative (if not client): _____

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 [describe good faith attempts]. However, because of [insert reasons why acknowledgement was not obtained] I was unable to obtain my patient's acknowledgement.

Signature of Provider: _____ Date: _____

Provider Name/License: _____