

**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 925-255-5499.

If you have any questions about my *Notice of Privacy Practices*, please contact me at:  
712 Bancroft Rd., #915, Walnut Creek, CA 94598, 925-255-5499.

I acknowledge receipt of the *Notice of Privacy Practices* of Meredith Reddoch, LMFT.

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

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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: \_\_\_\_\_