4944 Sunrise Blvd., Suite J-5 • Fair Oaks, CA 95628 • (916) 827-0071 • www.duffytherapy.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the HIPPA Notice of Privacy Practices that I have given to you or made available on my website for you to download. My HIPPA 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 HIPPA 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 916-642-5087.

If you have any questions about my Notice of Privacy Practices, please contact me at: 4944 Sunrise Blvd., Ste. J-5, Fair Oaks, CA 95628, phone 916-642-5087.

I acknowledge receipt of the HIPPA Notice of Privacy Practices of Christina Duffy, LMFT.

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 HIPPA Notice of Privacy Practices, including ____.

However, because of ______________________________________ I was unable to obtain my patient’s acknowledgement.

Signature of Provider: ______________________________ Date: ______________________
Christina Duffy, LMFT