Advanced Counseling and Testing Solutions LLC
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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 by contacting me at the phone number above.
If you have any questions about my Notice of Privacy Practices, please contact me at the address and /or phone number above.

I acknowledge receipt of the Notice of Privacy Practices of:

Advanced Counseling and Testing Solutions, LLC

Signature: _____ Date:_____
(patient/parent/guardian/conservator)

INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES ;
I made good faith attempts to obtain my patient's acknowledgement of his or her receipt of my Notice of Privacy Practices, including [describe good faith attempts].

_____
_____

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

_____
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