



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 (818) 434-5392.

If you have any questions about my *Notice of Privacy Practices*, please contact me at (818) 434-5392, 299 N. Euclid Ave., Ste 540, Pasadena, CA 91101

I acknowledge receipt of the *Notice of Privacy Practices* of Karen Martin Fiedler, M.S.

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 _____, I was unable to obtain my patient's acknowledgement.

Signature of Provider: _____ Date: _____