## 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 [310-275-1116].

If you have any questions about my *Notice of Privacy Practices,* please contact me at:

Karen E. Davis, Psy.D.
9720 Wilshire Boulevard
Suite 708
Beverly Hills, CA 90212

Telephone: 310-275-1116

I acknowledge receipt of the *Notice of Privacy Practices* of Karen E. Davis, Psy.D.

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 [describe good faith attempts]. However, because of [_____] I was unable to obtain my patient's acknowledgement.

Signature of Provider: _____Date: _____

**PLEASE PRINT THIS PAGE AND SIGN IT. RETURN A COPY TO DR. DAVIS.**