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**Acknowledgment of Receipt of Notice of Privacy Practices
(HIPAA)**

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 (949-412-4381). If you have any questions about my Notice of Privacy Practices, please contact me at: (27405 Puerta Real, Suite 330, Mission Viejo, CA 92691, 949-412-4381).

I acknowledge receipt of the Notice of Privacy Practices of Yoshimi Enger's, LMFT Notice of Privacy Practices.

*** You may refuse to sign this Acknowledgement

Client's Signature: _____ Date: _____

Client's Signature: _____ Date: _____

or

Name of Minor(s): _____ / _____

Parent(s)/ Legal Guardian (Print name): _____

Parent(s)/ (signature): _____ Date: _____

_____ Date: _____