**Acknowledgement of Receipt of Notice of Privacy Practices**

By signing this form, you acknowledge receipt of the Notice of Privacy Practices that was given to you. This provides information about how Kimberly Nelson LMFT may use and disclose your protected health information. I encourage you to read it in full.

The Notice of Privacy Practices is subject to change. If I change this notice, you may obtain a copy of the revised notice by contacting Kimberly Nelson.

If you have any questions about the Notice of Privacy Practices, please contact Kimberly Nelson at 325 Carlsbad Village Dr. Suite F-2 Carlsbad, CA 92011.

I acknowledge receipt of the Notice of Privacy Practices of Kimberly Nelson MLFT.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_

Client/parent/conservator/guardian

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_

Client/parent/conservator/guardian

Therapist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I made good faith attempts to obtain my clients acknowledgement of his or her receipt of Kimberly Nelson’s Notice of Privacy Practices, including\_\_\_\_\_\_\_\_\_\_\_\_

However, because of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I was unable to obtain my client’s acknowledgement.

Signature of Provider\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_