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

I acknowledge receipt of the *Notice of Privacy Practices* of Miriam Koenig, LMFT, LPCC.

Signature: _________________________________Date: ___________________________
(patient/parent/conservator/guardian)

For Office Use Only

A standard acknowledgement of the receipt of the notice of privacy practices was not obtained because:

_____Patient refused to sign

____Communication barriers prevented obtaining the acknowledgement

____An emergency situation

____Other

Signature of Provider:__________________________ Date:_________________________