Abraham Aviles-Scott
Licensed Marriage & Family Therapist

## Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices: Your Information, Your Rights, Our Responsibilities* 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 925-255-7704, or on my website aavilesscott.com.

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

Abraham Aviles-Scott
PO Box 372
Concord, CA 94522
925-255-7704
aavilesscott@gmail.com

I acknowledge receipt of the *Notice of Privacy Practices* of Abraham Aviles-Scott, LMFT.

Signature of patient/parent/conservator/guardian: _____

Date: _____

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## Inability to Obtain Acknowledgement of Receipt of Notice of Privacy Practices

I made good faith attempts to obtain my patient's acknowledgement of his or her receipt of my *Notice of Privacy Practices*, including: [describe good faith attempts] _____
_____
_____

However, I was unable to obtain my patient's acknowledgement because [insert reasons why acknowledgement was not obtained] _____
_____
_____

Signature of Provider: _____

Date: _____