Aurora Mandy LMFT #47273
3701 Lone Tree Way Ste 10B
Antioch, CA 94509
(925)864-4042 phone
(925)522-8085 fax

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 (925)864-4042.
If you have any questions about my *Notice of Privacy Practices*, please contact me at: (925)864-4042, 3701 Lone Tree Way. Antioch, CA 94509.

I acknowledge receipt of the *Notice of Privacy Practices* by *Aurora Mandy.*

Signature:_____Date: _____
(patient/parent/conservator/guardian)

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:_____