

SUZANNE R. BENKO, MFT, APC
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 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, I will provide you with the updated version. If you have any questions about my *Notice of Privacy Practices*, please contact me and I will be happy to provide additional information.

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 patient's acknowledgement of his or her receipt of my *Notice of Privacy Practices*, including

However, because of _____

I was unable to obtain my patient's acknowledgement.

Signature of Provider: _____ Date: _____