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

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:_____