

**Bay Area Marriage, Family & Child Counseling, Inc.  
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FREMONT, CA 94538  
(510) 612-6471**

**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. The most recent version will always be at my website at [www.shalinimft.com](http://www.shalinimft.com) in the Forms section. If I change my notice, you may obtain a copy of the revised notice from me by contacting me at the phone number above

If you have any questions about my Notice of Privacy Practices, please contact me at the address and /or phone number above

I acknowledge receipt of the Notice of Privacy Practices of Bay Area Marriage, Family & Child Counseling, Inc.

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 [describe good faith attempts].

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However, because of [describe reasons why acknowledgement was not obtained] I was unable to obtain my patient's acknowledgement.

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Signature of provider: - \_\_\_\_\_ Date: \_\_\_\_\_