Patient Acknowledgment of Receipt of Privacy Practices

I, _____ hereby acknowledge that I have received and reviewed a copy of this office's Notice of Privacy Practices explaining:

- How this office will use and disclose my protected health information.
- My privacy rights regarding my protected health information.
- This office's obligations concerning the use and disclosure of my protected health information.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request.

I understand that if I have any questions, I can reach out to the contact person listed below:

Teje Aliberti, MA. LMFT & LPCC
310-995-9772

_____ _____

Client Signature **Date**