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 (415) 350-7033.

If you have any questions about my *Notice of Privacy Practices,* please contact me at: (415) 350-7033.

I acknowledge receipt of the *Notice of Privacy Practices* of Sarah Foxfire.

Signature:_________________________________Date: ______________________

(patient/parent/conservator/guardian)

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