Lorene Noack, LCSW
LCS 20518

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 530.575.0363

If you have any questions about my Notice of Privacy Practices, please contact me at: 530.575.0363.

I acknowledge receipt of the Notice of Privacy Practices of Lorene Noack, LCSW.

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 patients 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: