COMMUNITY INSTITUTE FOR PSYCHOTHERAPY

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient or Subscriber Name:_____
(Please print patient or subscriber name)

I,_____,
(Print name of client, subscriber, conservator, parent or legal guardian signing below)

acknowledge receipt of the Notice of Privacy Practices that describes how my medical information may be used and disclosed by the County of Marin and how I can get access to my medical information.

_____.
(Name of facility, provider or program)

Signed:_____ Date:_____

If not signed by patient, indicate relationship:_____

Note: Parents must have legal custody. Legal guardians and conservators must show proof.

This section to be filled out only by CIP

Patient did receive the Notice of Privacy Practices (print or audio tape), but did not sign this form because:

- ☐ Patient left the office before the Acknowledgment form could be signed.
- ☐ Patient refused to sign the Acknowledgment form.
- ☐ Patient cannot sign the Acknowledgment form because:_____

Patient did not receive the Notice of Privacy Practices (print or audio tape format) because:

- ☐ Patient required emergency treatment.
- ☐ Patient declined to accept a print copy of the Notice and declined to sign this Acknowledgment form.
- ☐ Patient refused to listen to an audio tape version of the Notice and declined to sign this Acknowledgment form.
- ☐ Other:_____

Name:_____
(Print name of provider or provider's representative)

Signed:_____ Date:_____
(Signature of provider or provider's representative)