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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) 668-5130.

If you have any questions about my *Notice of Privacy Practices*, please contact me at: 16 Blake Street, San Francisco, CA 94118 (415) 668-5130

I acknowledge receipt of the Notice of Privacy Practices of Kathleen Dunbar, MFT

Signature: _____ Date: _____
(patient/parent/conservator/guardian)