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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 818-798-8086.

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

I acknowledge receipt of the *Notice of Privacy Practices* of *Deonae Shackelford, LCSW*

_____ _____
Client Name (Please Print) Date

_____
Signature of Client/Parent/Conservator/Guardian
(Specify Relationship to Client)

_____ _____
Client Name (Please Print) Date

_____
Signature of Client/Parent/Conservator/Guardian
(Specify Relationship to Client)

_____, _____
Deonae Shackelford, MSW, LCSW Date
Treating Therapist
LCSW #121067