Mary Anne Gallagher, Ph.D.
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818-243-5674

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge that I have made my *Notice of Privacy Practices* available to you. My *Notice of Privacy Practices* provides information about how I may use and disclose your protected health information. It can be accessed on my website, www.maryannegallagher.com, at any time. 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 818-243-5674, or by going to my website.

If you have any questions about my *Notice of Privacy Practices,* please contact me at: 2550 Honolulu Avenue, Suite 103, Montrose, CA 91020, 818-243-5674.

I acknowledge receipt of the *Notice of Privacy Practices* of Mary Anne Gallagher, Ph.D.

***Signature*: ____**

***Date:* _________________**

(patient/parent/conservator/guardian)

INABILITY TO OBTAIN ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

***I made good faith attempts to obtain my patient's acknowledgment of his or her receipt of my Notice of Privacy Practices. However, because of* ____I was unable to obtain my patient's acknowledgment.**

Signature of Provider:____________________________________

Date: _________________

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