

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION
PRIVACY PRACTICES**

I HEREBY ACKNOWLEDGE receipt of:

- Planned Parenthood of San Diego and Riverside Counties' Notice of Health Information Privacy Practices
- FPACT's Notice of Health Information Privacy Practices

Please print your name, sign and date as indicated below:

Name: _____
(please print)

Signature: _____

Date: _____

(A copy of this acknowledgment will be kept in your patient file.)

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

- PPSDRC's Notice of Health Information Privacy Practices
- FPACT's Notice of Health Information Privacy Practices

Signature of Planned Parenthood Representative: _____

Date: _____