

**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.

If you have any questions about my *Notice of Privacy Practices*, please contact me at:
[DrJ@drstephenjohnson.com].

I acknowledge receipt of the *Notice of Privacy Practices* of Dr. Stephen J. Johnson, Ph.D., LMFT.

Signature: _____

Print name: _____

Date: _____