Childhood Autism Treatment Team / Childhood Autism Therapies	
Name of Pat	ient:
Patient Date of Birth:	
Ackı	nowledgement of Receipt of Notice of Privacy Practices
I acknowledge that I have received a copy of Provider's Notice of Privacy Practices with the effective date of 1-1-2011	
Signature of I	Patient/Patient Representative Date
Relationship	to Patient
Documentation of Good Faith Efforts To obtain patient's acknowledgment that they received provider's Notice of Privacy Practices	
(For use when acknowledgment cannot be obtained from the patient.)	
The patient presented to the office/therapist on(date) and was provided with a copy of Covered Entity's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgement was not obtained because:	
	Patient refused to sign. Patient was unable to sign or initial because:
	The patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity. Other reason (describe below):
Signature of I Date Signed:	Employee Completing Form:
Date Signed.	

Receipt of Privacy Notice.doc Jan 2011