

Kyle Williams LMSW ACSW
17 N. 4th Street, Ste 211 / Grand Haven, MI 49456

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (01/01/16)

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. The most recent version will always be at my website at www.KyleWilliams.net in the Forms section. If I change my notice, you may obtain a copy of the revised notice from me by contacting me at the phone number above.

If you have any questions about my Notice of Privacy Practices, please contact me at the address and /or phone number above

I acknowledge receipt of the Notice of Privacy Practices of Kyle Williams, LMSW ACSW

Signature: _____ Date: _____
(patient/parent/conservator/guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT 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: _____