South Coast
Psychological
Services

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below, I ______________________________________, acknowledge that I have received a copy of the California HIPAA Notice Form for South Coast Psychological Services.

_____________________________ _____________________________ ____________

Signature of Responsible Party | Print Name | Date

This form will be retained in your medical record.

South Coast Psychologist Services
901 Dove Street, Suite 150 ◦ Newport Beach, CA 92660
southcoastpsych.com