



SHRINK RAP HIPPA ACKNOWLEDG

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Date: _____

Name of Client: _____ Date of Birth: _____

I, [name of patient or parent or guardian] _____, acknowledge and agree that I have received a copy of Shrink Rap, Inc. Notice of Privacy Practices.

I give Dr. Gurri, Shrink Rap, and the office to use email, voicemail, text, fax, and mail to contact me as needed.

Client or Guardian Signature

Date

Print Name of Legal Representative Relationship to patient

FOR SHRINK RAP OFFICE USE ONLY:

Shrink Rap, Inc. made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices:
[Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if known) why the written acknowledgment was not obtained.]

Signed form received by: _____

Acknowledgement denied: _____

Efforts to obtain: _____

Reasons for refusal: _____
