



The office of
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HIPAA: 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 818-599-5986 or IlonaStrasserLMFT@gmail.com

I acknowledge receipt of the *Notice of Privacy Practices* of Ilona Strasser, LMFT.

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

A handwritten signature in black ink, appearing to read 'Ilona Strasser', written over a horizontal line.

Ilona Strasser, LMFT