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### **Receipt and Acknowledgment of Privacy Practices Notice**

I hereby acknowledge that I have received a copy of Dr. Kauffman's Notice of Privacy Practices of the Health Insurance Portability and Accountability Act (HIPAA) and had the opportunity to ask questions and discuss the privacy rights described therein. I understand that if I have further questions regarding the Notice or my privacy rights, I can contact my therapist at her telephone number.

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Signature of Client/Guardian

Date

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Printed Name of Client