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NOTICE OF PRIVACY PRACTICES

Patient Name_____

I hereby acknowledge that I have received a copy of this medical practice's "Notice of Privacy Practices". I further acknowledge that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Printed Name_____

Signed_____Date_____

If not signed by patient, please indicate your relationship to the patient:
Printed Name:_____
Relationship_____

Patient/Guardian
Signature_____Date_____

Office use only:
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