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HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of our HIPAA Notice of Privacy Practices.

_____
Patient Name (please print)

_____ _____
Patient Signature Date

OR

_____ _____
Signature of Personal Representative Date

Authority of Personal Representative to Sign for Patient (check one):

❑ Parent ❑ Guardian ❑ Power of Attorney ❑ Other _____

Please Note: It is your right to refuse to sign this Acknowledgement.