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Notice of Privacy Practices Receipt

I acknowledge that I was provided with the Notice of Privacy Practices of the Medical Practice named at the top of this page and have reviewed it. I understand that I am entitled to receive a copy of this document.

Print Name of Patient: _____
 Signature of Patient: _____
 Date: _____
 Patient's Date of Birth: _____

For Personal Representative of the Patient (if applicable)

Print Name of Personal Representative: _____
 Describe Personal Representative
 Relationship (parent, guardian, etc): _____
 Signature of Personal Representative: _____
 Date: _____

For Practice Use Only:

 Signature of Practice Employee

 Date