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## **Acknowledgement of Receipt of Notice of Privacy Practices**

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I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Telephone: \_\_\_\_\_

If not signed by the patient, please indicate relationship:

- Parent or guardian of minor patient
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Name and Address of Patient: \_\_\_\_\_

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