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Acknowledgement of Receipt OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how my health information may be used and/or disclosed, and how I may obtain access to and control this information.

Signature of Patient or Authorized Personal Representative

Print Name of Patient or Authorized Personal Representative

Date

Description of Personal Representative's Authority
(e.g., parent or legal guardian)