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ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

I acknowledge that I was provided with a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Please allow the following family members to receive information:

Name:	Relationship:
_____	_____
_____	_____
_____	_____

_____
(Patient Name) PLEASE PRINT

_____
(Name of Parent or Authorized Representative…if applicable)

_____ _____
(Signature) (Date)