Acknowledgement of Review of Notice of Privacy Practice

I am aware of this office's Notice of Privacy Practices. It explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

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Patient's Name

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Name of Parent or Personal Representative *(anyone you would not mind getting information, ie. appointment info, test results, surgery info.)*

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Relationship to Personal Representative's Authority *(spouse, child, relative, ect.)*

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Signature Patient or of Guardian (if patient under 18years of age) *Date*

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Witness