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Acknowledgment of Receipt of Privacy Policy

The following signature acknowledges that I have received a written notification of my privacy rights concerning the use and disclosure of my protected health information as defined by the Health Insurance Portability and Accountability Act of 1996.

Patients Name: _____
Date of Birth: _____

Patients Name: _____
Date of Birth: _____

Patients Name: _____
Date of Birth: _____

Signature of Patient or Guardian: _____

Date: _____

Printed Name: _____