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ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

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

_____ _____

Patient Name (please print) (Date)

_____

Parent or Authorized Representative (if applicable)

_____

Signature