HIPAA

NOTICE OF PRIVACY PRACTICES - ACKNOWLEDGEMENT

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Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By signing this form, I acknowledge receipt of the Notice of Privacy Practices.

_____ _____
Patient or legally authorized individual's signature Date

_____ _____
Printed Name Date

This form will be retained in your medical record.

Staff Initials _____ Date _____