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Receipt of Notice of Privacy Practices

I, _____, hereby acknowledge receipt of physician's
(Patient's Name)
Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

Signed: _____Date:_____

If you are not the patient, please specify your relationship to the patient. _____