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## Acknowledgment of Receipt of Privacy Notice

***Original to be maintained in patient's permanent medical record.***

I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

| | |
|---|---|
| Patient or legally authorized individual signature | Date |
| Printed Name if signed on behalf of the patient | Relationship (parent, legal guardian, personal representative, etc.) |

**Original Effective Date:** December 1, 2003
Effective Date of Last Revision (if any): _____