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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): ______________________________