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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I hereby acknowledge that I received a copy of this	s medical practice's Notice of Privacy Practice.
Print Name:	
Signature:	Date:
If not signed by patient, please indicate relationshi	p to patient below:
? Parent or guardian of minor patient	
? Guardian or conservator of an incompetent patient.	
? Beneficiary of personal representative of deceased patient.	
Name of Patient:	