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**NOTICE OF PRIVACY PRACTICES**  
**PATIENT ACKNOWLEDGEMENT**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I have received this office's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the office's legal duties with respect to my information.

I understand that this office reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information residing at, or controlled by this office. I understand I can obtain this office's current Notice of Privacy on request.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Relationship to patient (if signed by a personal representative of patient):

\_\_\_\_\_  
Signature