ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I HAVE REVIEWED THE OFFICE'S NOTICE OF PRIVACY PRACTICES, WHICH EXPLAINS HOW MY MEDICAL INFORMATION WILL BE USED AND DISCLOSED. I UNDERSTAND THAT I AM ENTITLED TO RECEIVE A COPY OF THIS DOCUMENT.

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SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

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DATE

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NAME OF PATIENT OR PERSONAL REPRESENTATIVE

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DESCRIPTION OF PERSONAL REPRESENTATIVE AUTHORITY