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I acknowledge that I have received a copy of the Notice of Privacy Practices as required under the Health Insurance Policy and Accountability Act (HIPPA). The notice I received describes how medical information about me may be used and disclosed and how I can get access to this information, including information on where to file a complaint regarding disclosure and use of protected health information under HIPPA.

_____ _____
Print Name of Patient Date

_____ _____
Patient Signature or Patient's Guardian/Custodian Date

_____ _____
Print Name of Patients' Guardian/ Custodian if Applicable Date