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## **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six (6) years.

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PATIENT NAME (PLEASE PRINT)

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SIGNATURE

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PARENT, GUARDIAN, OR PATIENT'S LEGAL REPRESENTATIVE

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DATE

**THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED  
FOR SIX (6) YEARS.**