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**NOTICE OF PRIVACY PRACTICES  
ACKNOWLEDGEMENT OF RECEIPT**

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The HIPPA Notice of Privacy Practices provides information about how we may use and Disclose protected health information about you.

I acknowledge that I have received the Notice of Privacy Practices.

\_\_\_\_\_  
**Signature of Patient or Patient's Representative**

\_\_\_/\_\_\_/\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Relationship to Patient**

\_\_\_\_\_  
**Name of Interpreter (If applicable)**

If written acknowledgement is not obtained, please check reason:

- Notice of Privacy Practices Given- Patient Unable to Sign
- Notice of Privacy Practices Given- Patient Declined to Sign
- Other \_\_\_\_\_

\_\_\_\_\_  
**Dr. Signature**

\_\_\_/\_\_\_/\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Department**