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Notice of Privacy Practices Receipt

I acknowledge that I will be provided with the Notice of Privacy Practices of the Medical Practice named at the top of this page upon my request.

Print Name of Patient:	
Signature of Patient:	
Date:	
Patient's Date of Birth:	

Print Name of Personal Representative:	
Describe Relationship:	
Signature of Personal Representative:	
Date:	

Signature of Practice Representative:	
Date:	

Access Log

Date	Requestor	Records Sent	To Whom	Initials of Sender