

**Notice of  
HIPPA Privacy Practices ---- Acknowledgement**  
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Our Notice of HIPPA Privacy Practices describes in more detail how your health information may be used and disclosed. **By signing this form, I acknowledge receipt of the HIPPA Notice of Privacy Practices.**

\_\_\_\_\_  
Patient or legally authorized individual's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date