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RECEIPT OF THE NOTICE OF PRIVACY OF PRACTICE

Patient's Full Name: _____ DOB: _____

Patient's Address: _____

Patient's Phone Number: (H) _____ (W) _____

Date the Notice was Provided: _____

Patient's Signature _____

Signature of Guardian or Legal Representative: _____

Relationship to Patient: _____

Individual Refused to Sign: _____ Date: _____