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## Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

By signing this form, I authorize you to release confidential health information about me to the following person(s):



\_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Relationship)

\_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Relationship)

\_\_\_\_\_  
**Printed Name of Patient**

\_\_\_\_\_  
**Signature of Patient or Legal Guardian**

\_\_\_\_\_  
**Printed Name of Legal Guardian**

\_\_\_\_\_  
**Relationship of Legal Guardian**

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