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Date: _____

ACKNOWLEDGMENT AND CONSENT HIPPA

By signing below, I acknowledge that I have read the Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the physician private practice listed at the beginning of this notice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV/AIDS related information, alcohol and substance abuse treatment information, mental health information, and generic information, finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of this practice, its physicians, and staff.

1. Signature of Patient OR Patient's authorized Representative

2. Print Name of Patient OR authorized Representative

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