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**ACKNOWLEDGEMENT OF RECEIPT OF HIPPA NOTICE
OF PRIVACY PRACTICES**

Name: _____
(PRINTED NAME)

Signature of Patient Representative: _____ Relationship: _____

COMMUNICATION REGARDING YOUR PROTECTED HEALTH INFORMATION

List person(s) whom we may release your health information to: _____

May we leave messages regarding appointment information, test results and/or treatments on your voicemail? **Yes** or **No** If yes, Phone # (____) ____ - _____

Signature: _____ Date: _____