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**ACKNOWLEDGEMENT OF RECEIVING NOTICE OF PRIVACY  
PRACTICES  
AND HEALTH CARE PROVIDER DISCLOSURE**

I, \_\_\_\_\_ [patient name], or  
the parents or legal guardian of the patient, have reviewed the following  
documents:

[Write your initials to acknowledge receipt of documents]

\_\_\_\_\_ Notice of Privacy Practices

\_\_\_\_\_ Consent To Disclose PHI

\_\_\_\_\_  
Signature of Patient (or Parent or Legal Guardian)

\_\_\_\_\_  
Date