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NOTICES OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

I have received the attached Notice of Privacy Practices.

______________________________	____________________
Signature of Client	Signature Date
______________________________	____________________
Print Name	Date of Birth of the Client
______________________________	____________________
Signature of Parent/Legal Guardian/ Legal Representative	Relationship to Client
______________________________	____________________
Witness (if not signed by Client)	Signature Date