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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

Submit