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Notice of Privacy Practices

Your rights, our responsibilities

This notice describes how medical or psychiatric information about you may be used and disclosed.

Please review it carefully.

I, _____, acknowledge I have read, reviewed, understand, received a copy and had an opportunity to ask questions in reference to the Notice of Privacy Practices.

If you would like a copy emailed to you, please provide your email address below:

_____

_____

_____ _____

Patient/Guardian Signature Date