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**Receipt of Notice of Privacy Practices**

**Under The Health Insurance Portability And Accountability Act (HIPAA) Privacy Rule**

My signature below acknowledges that I have received the **“Notice of Privacy Practices ”**.

This notice describes how psychological and medical information about me may be used and disclosed, and how I can get access to this information under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

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Signature of Patient Date

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Printed Name of Patient