

**OBSTETRICS and GYNECOLOGY**

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**Acknowledgment of Receipt of Privacy Notice**  
*Original to be maintained in Patient's permanent medical record.*

**I acknowledge that I have received a copy of the office's Notice of Privacy Practices.**

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed Name**

**\* Minors - Please be advised by signing above you are granting permission for this office to disclose medical information to your parents.**

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**Initial**