

NOTICE OF PRIVACY PRACTICES (HIPPA)

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THE NOTICE DESCRIBES HOW MEDICAL/DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY AND SIGN BELOW.

I hereby have reviewed and understand the HIPPA information that was given to me. I was able to review the information and ask questions regarding my rights and the privacy practice.

SIGNATURE OF PATIENT, PARENT or GUARDIAN _____ DATE _____