HIPAA Acknowledgement

Patient's Name ___________________________

Your signature below indicates that you have read this HIPAA Agreement and agree to its terms and also serves as an acknowledgement that you have received the HIPAA notice form described above

_________________________ ____/____/____
Patient Signature Date

_________________________ ____/____/____
Signature of Personal Representative Date

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided;

______ Parent

______ Guardian

Other: ____

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