PDX ENT
& AUDIOLOGY
MEDICAL GROUP

Notice of Privacy Practices Acknowledgment

I acknowledge that I have received a copy of the

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Name of physician/physician group)

Notice of Privacy Practices

By signing below, I agree that **I HAVE RECEIVED** a copy of the notice of Privacy Practices.

_______________________________ _______________

Patient Signature Date

____

Print Patient Name

_______________________________ _______________

Parent, Guardian, Responsible Party, Legal Representation Signature Date

____

Description of Representative Authority

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