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## **HIPAA NOTICE OF PRIVACY PRACTICES**

I keep medical records of the health care services I provide for you. You may ask to see and copy your records. You may ask to correct your records. Your records will be kept confidential unless you give me written permission to release them or I am required to do so by law. I will ask you to sign a consent form allowing me to use and disclose your health information for purposes of treatment, payment and healthcare operations in this office. You may see your records or get more information about them by contacting my office.

For more information about our privacy practices please inquire with me.  
By signing below, I acknowledge receipt of the Notice of Privacy Practices.

\_\_\_\_\_  
Signature of patient or legal representative

\_\_\_\_\_  
Date