

# NOTICE OF PRIVACY PRACTICES

I have had the opportunity to read this office’s complete Notice of Privacy Practices which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Would you like a copy of the Notice of Privacy Practices?

* Yes
* No

I understand that this office will share my information will all members of my treatment team, both within this office and with other providers (personal and institutional) in order to provide me with quality care.

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Staff Signature

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Client Printed Name

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Client Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Parent or Guardian Signature (if under 18)