Submit To IMP Wellness

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# ACKNOWLDEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I_____acknowledge that I have received a copy of
(Name of patient)
Internal Medicine & Pediatrics Wellness Center's Notice of Privacy Practices. This Notice describes how Internal Medicine & Pediatrics Wellness Center may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____
(Signature of Patient, or Personal Representative) (Date)

_____
(Relationship to Patient)