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Privacy Notice Patient Acknowledgement Form

By signing below, I am acknowledging that I have received a copy of Dr. Awan's Privacy Notice.

Patient Name (Print): \_\_\_\_\_ Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

OR

Patient Representative: \_\_\_\_\_

(Print Name)

Relationship to Patient: \_\_\_\_\_

(Parent, Guardian, etc.)

Patient Representative:

\_\_\_\_\_

Date: \_\_\_\_\_

(Signature)