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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I received a copy of Oregon Neurology Notice of Privacy Practices.

Print Patient Name:_____ DOB:_____

Signature of Patient/
Responsible Party:_____ Date: _____

If not signed by the patient, please indicate the relationship to patient: _____

FOR CLINIC USE ONLY:

☐ Acknowledgement refused. Describe good faith efforts to obtain acknowledgement:

_____

☐ Acknowledgement not obtained for the following reason:

_____