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**HIPAA Privacy Practices Receipt and  
Acknowledgment of Notice**

Patient Name: \_\_\_\_\_

I hereby acknowledge that I have received and have been given an opportunity to read a copy of the HIPAA Notification of Privacy Practices. I understand that if I have any questions regarding this notice or my privacy rights, I may contact DepthWorks, PLLC or Tony Delmedico at (919) 623-8118.

\_\_\_\_\_  
Signature of Patient or Legal Representative\*

\_\_\_\_\_  
Date

\* If you are signing on behalf of someone, please describe your legal authority to act for this individual (i.e. parent, guardian, legal custodian, power of attorney, healthcare surrogate).