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**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I \_\_\_\_\_ acknowledge that I have received a  
(Name of Parent)  
copy of Dr. Gorlovsky's Notice of Privacy Practices for my child. This Notice describes how Dr. Gorlovsky may use and disclose my child's protected health information, certain restrictions on the use and disclosure of my child's healthcare information, and rights I may have regarding the protected healthcare information.

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(Signature of Parent, or Personal Representative) (Date)

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(Relationship to Patient)