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Acknowledgement and Receipt of Privacy Practices

This lactation consultation practice is required by US federal law to maintain our patients' privacy and provide them with access to the notice of our legal duties and privacy practices with respect to protected health information (PHI). Your signature below hereby acknowledges that you have reviewed our HIPAA Notice of Privacy Practices document and understand that you may obtain a copy for your records upon request.

Printed Name _____

Signature _____

Today's Date _____