McMorries
OBSTETRICS, GYNECOLOGY & INFERTILITY

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RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document upon request.

I understand that this office will attempt to contact me on any study ordered, and if I have not been notified of the result within 21 days, it is my responsibility to contact the office.

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Signature of Patient/Personal Representative Date