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## **ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES**

I have reviewed Greater Austin Orthopaedics' 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.

Patient/Guarantor Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Name of Patient or Personal Representative: \_\_\_\_\_

Description of Personal Representative's Authority: \_\_\_\_\_