Acknowledgement of Receipt of Notice of Privacy Practices

Bruce W. Hallmann, M.D., S.C, reserves the right to modify the privacy practices outlined in this notice

Signature

I have received a copy of the Notice of Privacy Practices for Bruce W. Hallmann, M.D., S.C.

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Name of Patient

____
Signature of Patient

____
Date

____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

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Relationship of Patient Representative to Patient