Framingham Podiatry

Acknowledgement of Receipt of Notice Privacy Practices

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Last Name First Name Middle Init Date of Birth Telephone

Home Address: Street City/Town State Zip Code

Parent/Family Member/Legal Guardian/Personal Representative's Name

I acknowledge that I have received Framingham Podiatry's *Notice of Privacy Practices*.

Signature of Patient or Personal Representative Date

If you are signing this acknowledgement in your capacity as a personal representative, please describe your authority to act on behalf of the patient and your relationship to the patient.