

# E.N.T. SURGICAL GROUP

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I \_\_\_\_\_ acknowledge that i have received a copy of The E.N.T. Surgical Group, P.C. Notice of Privacy Practices. This notice describes how The E.N.T. Surgical Group, P.C. may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights regarding my protected health information.

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(Signature of Patient, or Personal Representative)      (Date)

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(Relationship to Patient)