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ACKNOWLEDGEMENT OF REVIEW OF PRIVACY PRACTICES

I have reviewed the notice of privacy practices for Dr. Christopher Serrano's office and I understand how my medical information will be used and when it will be disclosed. I understand that I am entitled to receive a copy of this document.

_____
Name of patient or Guardian (PLEASE PRINT)

_____
Signature of patient or Guardian

_____
Date

_____
*Description of Personal Representative's Authority

*Should patient be of legal age and a Power of Attorney been issued, we must have a copy in our files before any information can be released.