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**PATIENT ACKNOWLEDGMENT OF RECEIPT OF THE NOTICE OF  
PRIVACY PRACTICES – REVISED 1/1/14 (MASSACHUSETTS NOTICE  
FORM)**

My signature below attests to the fact that I have received a copy of the NOTICE OF  
PRIVACY PRACTICES AND POLICIES dated 1/1/14.

\_\_\_\_\_  
Signature of Patient or Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient or Parent/Guardian

\_\_\_\_\_  
Date