

IN VITRO FERTILIZATION CENTER

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PATIENT ACKNOWLEDGMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES
FOR PROTECTED HEALTH INFORMATION

By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices.

✓ _____
Print Patient or Personal Representative Full Name

✓ _____
Signature of Patient or Personal Representative

✓ _____
Date

Description of Personal Representative's Authority