



Nirschl Orthopaedic Center for Sports Medicine & Joint Reconstruction

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PATIENT ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

Patient's Name: _____

I acknowledge receipt of the Notice of Privacy Practices given to me by Nirschl Orthopaedic Center for Sports Medicine and Joint Reconstruction.

Signature of Patient or Legal Representative Date _____

If Signed by Representative, Relationship to Patient: _____