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**Acknowledgement of Receipt of Notice of Privacy Practices**

VALLEY UROLOGICAL ASSOCIATES reserves the right to modify the privacy practices outlined in this notice.

I have received a copy of the Notice of Privacy Practices for VALLEY UROLOGICAL ASSOCIATES.

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Name of Patient

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Signature of Patient

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Date

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Signature of Patient Representative  
(Required if the patient is a minor or an adult who is unable to sign this form)

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Relationship to Patient