Simi Obstetrics & Gynecology Medical Group, Inc.
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Notice of Privacy Practices Acknowledgement Form

THE NOTICE OF PRIVACY PRACTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMAITON. PLEASE REVIEW IT CAREFULLY.

I acknowledge that I have received the office Notice of Privacy Practices. I further acknowledge that the office Notice of Privacy Practices is available at the front desk upon request.

_____ _____
Patient or Patient Representative Signature Date

_____ _____
Patient or Patient Representative Printed Name Patients Birth Date