



Riverside Orthopaedic  
and Sports Medicine  
A S S O C I A T E S

**ACKNOWLEDGMENT OF RECEIPT**  
**OF**  
**NOTICE OF PRIVACY PRACTICES**

*I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.*

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Patient Name *(please print)*

Date

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Parent or Authorized Representative *(if applicable)*

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Signature