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Notice of Privacy Practices (HIPAA Acknowledgement/Consent)

I hereby acknowledge that:

- I have reviewed the Bucks County Anxiety Center Privacy Policy document on the practice web site.
- I can access the Bucks County Anxiety Center Privacy Policy on the practice website at any time.
- I can print off a copy of Bucks County Anxiety Center's Privacy Policy from the website at any time.

In addition, I hereby consent to the use and disclosure of mine and/or my child's personal health information for the purposes of treatment, payment, and health care operations.

Patient Signature:

Date:

Parent/Guardian Signature:

Date: