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Acknowledgement of receipt of:

**‘NOTICE OF PROTECTED HEALTH INFORMATION  
PRACTICES’**

I \_\_\_\_\_ acknowledge that I have read and or received a copy of Daniel J. Hopson, M.D., P.A., Paul W. Hurd, M.D., P.A., and Shari Rosen-Schmidt, M.D., P.A.: “Notice of Protected Health Information Practices”.

This notice describes how Daniel J. Hopson, M.D., P.A., Paul W. Hurd, M.D., P.A., and Shari Rosen-Schmidt, M.D., P.A. may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

Signature of Patient or Guardian \_\_\_\_\_

Date \_\_\_\_\_