**Patient Written Acknowledgment Confirming Receipt of Privacy Notice**

I acknowledge receiving a copy of Indulge in Nutrition, LLC HIPAA Privacy Practices.

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Printed Patient Name

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Signature of Patient Date

If patient is under 18 years, guardian’s signature

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Printed Guardian Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Guardian Date