JAMES D. WETHE, MD

Acknowledgement of Receipt of Notice of Privacy Practices

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Your signature on this form acknowledges your receipt of the Notice.

I acknowledge that I have received a copy of the Notice of Privacy Practices for the office of James D. Wethe, MD.

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Please print your name here

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Signature

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Date

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Date of Birth