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| **THE BERKELEY THERAPY INSTITUTE** | | | | | | | | |
| **1749 MARTIN LUTHER KING, JR. WAY** | | | | | | | | |
| **BERKELEY, CALIFORNIA 94709** | | | | | | | | |
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| **TELEPHONE (510) 841-8484** | | | | | | | | |
| **FACSIMILE (510) 540-1707** | | | | | | | | |

**ACKNOWLEDGEMENT OF RECEIPT OF**

**NOTICE OF PRIVACY PRACTICES**

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have reviewed a copy of this office’s HIPAA Notice of Privacy Practices. I understand that I may request a copy of this notice for my records. I may also request amended copies be sent to me by email, when applicable.

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Signature

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

Date

If not signed by the patient, please indicate your relationship to the patient:

* parent or guardian of minor patient
* guardian or conservator of an incompetent patient
* other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

And include name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_