DR. GLENA J. DAVIS
OBSTETRICS/GYNECOLOGY
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name _____

Date of Birth _____

I acknowledge that Glena Davis, D.O. provided me with a written copy of her Notice of Privacy Practices and Patient's Rights and Responsibilities.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

_____ _____
Patient Signature Date

_____ _____
Personal Representative Signature (if applicable) Relationship to Patient

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