

Simpson Medical Equipment Inc.

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HIPAA Privacy Practices Acknowledgment

Please print clearly. If you have questions, call our office during business hours.

Patient Name

Date of Birth (MM/DD/YYYY)

I acknowledge that I have been offered a copy of Simpson Medical Equipment Inc.'s Notice of Privacy Practices. I understand that Simpson Medical Equipment Inc. may use and disclose my health information as described in the Notice. I understand I may request a copy of the Notice at any time.

Patient/Authorized Representative Signature

Date