NORTHLAND WOMEN'S HEALTH CARE, P.C.
OBSTETRICS / GYNECOLOGY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*** You May Refuse to Sign this Acknowledgement ***

All fields are required

I, _____ have received a copy of this office's Notice of Privacy Practices

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Patient Signature – Draw your signature below using a tablet, mouse or smartphone.
By clicking the Submit button at the end of this form I understand and agree that this is a legal representation of my signature(s).

Date _____

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Signature