

**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PATIENT INFORMATION PRIVACY PRACTICES**

My signature below indicates that I have been given the Notice of Patient Information Practices for Pitman Creek Physical Therapy, P. C. I recognize that outside of purposes for treatment, for payment, for certain healthcare operations, or as permitted or required by law, I must give my written authorization to Pitman Creek Physical Therapy, P. C. to release any of my protected healthcare information.

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Patient's or Authorized Representative's Printed Name & Date

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Patient's or Authorized Representative's Signature and Date