

**I have read and understand the Notice of Privacy Practices and understand that I may request a paper copy of this notice at any time. At this time, I waive my right to a paper copy.**

**Patient Name :** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Guardian/Parent Signature :** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**(if under 18 years of age)**