Notice to patient:

We are required to provide you with a copy of our notice of privacy practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of this notice.

**I acknowledge that I have received a copy of Southside Medical Center's Notice of Privacy Practices.**

**I give permission to Southside Medical Center to review my medication/prescription history if necessary**.

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**Print Name Here**

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**Signature**

_____

**Date**