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LaRocca Medical Weight Loss
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HIPAA Disclosure / Private Health Information (PHI)

Patient name: (First) _____ (Last) _____
Date of birth: _____/_____/_____

I, _____, have read and understand the LaRocca Medical Weight Loss Notice of Privacy Practices. All my questions have been answered to my satisfaction.

_____ _____
Patient's Name (printed) Date

_____
Patient Signature
(or signature of person with authority to consent for patient)