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HIPPA ACKNOWLEDGEMENT

I_____________________________ , have read the Privacy Policy and Theft Detection and Response Procedures of **Dr. Jon Nickelsen,** and understand the contents. I have been instructed regarding situations that may suggest possible identity theft as described in the Identity Theft Detection and Response Policy and Procedures.

I authorize the office of **Dr. Jon Nickelsen** to disclose protected health information to other health and dental providers to assist them in providing treatment to me.

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Print Name

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Signature Date