

**HEMATOLOGY & ONCOLOGY ASSOCIATES
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**ACKNOWLEDGEMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES**

Patient's Name: _____

ID Number: _____

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices of Hematology & Oncology Associates of Rhode Island, Inc.

Signature of Patient or Representative

Date

Printed Name of Patient of Representative

Relationship of Representative

REPRESENTATIVE INFORMATION

The contact information of the representative who signed this form should be filled out below:

Address

City, State, Zip Code

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