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I have received a paper copy of the Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), specifically the Standards for Privacy of Individually Identifiable Health Information. I also give my permission for my treatment, my children's treatment, and/or my family's treatment to be discussed in advanced supervision or professional consultation as needed. I understand that identifying information will remain confidential in the supervision/consultation process.

Signed and Dated:

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Printed Name and Date:

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