

# Barrett Clinic

8074 South 84<sup>TH</sup> Street  
Lavista, NE 68128

By Signing, I hereby acknowledge that I received a copy of the Notice of Privacy Practices from Barrett Clinic, PC

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Patient Signature \_\_\_\_\_

OR

Signature of guardian \_\_\_\_\_

Relationships to Patient \_\_\_\_\_

DATE \_\_\_\_\_