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# Receipt

## ***Agency for Persons with Disabilities***

### ***HIPAA Notice of Privacy Practices***

I hereby acknowledge receipt of the HIPAA Notice of Privacy Practices published by the Florida Agency for Persons with Disabilities (APD). This brochure explained how APD uses and protects my personal health information.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_