



Frank P. Holladay, MD, FACS
Kellie A. Stewart, RN, MSN, APRN

8919 Parallel Parkway, Suite 331
Kansas City, KS 66112
Phone: 913-955-3300
Fax: (913) 653-8950

NOTICE OF RECEIPT OF PRIVACY PRACTICE INFORMATION

Date: _____

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Patient Name: _____

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Parent or Guardian (if under 18): _____

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