



## **Acknowledgement of Receipt of Notice of Privacy Practices**

*\*You May Refuse to Sign This Acknowledgment\**

**By signing below, I acknowledge that I have received a copy of this office's Notice of Privacy Practices.**

\_\_\_\_\_  
Printed Patient Name

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
List anyone that may have access to the patient's protected health information.

**Please check the ways in which we may communicate with you:**

- Email
- Cell phone
- Home phone
- Work phone

- Spouse/partner's phone
- Parent's phone
- Other, Please list: \_\_\_\_\_

*If you need to change your preferences indicated on this form or if you have any questions, please contact the Privacy Official, Cathy Davis, at (817) 656-9366.*