ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Texas Breast Specialists is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information. Please sign below to acknowledge that you have received our Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Texas Breast Specialists.

Printed Name: _____

Signature: _____

Name of Personal Representative (if applicable): _____

Signature of Personal Representative (if applicable): _____

Date: _____

TEXAS BREAST SPECIALISTS USE ONLY

Date acknowledgment received: _____

OR

Reason acknowledgement was **NOT** obtained: _____

_____

_____

_____

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