Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of [TAYLOR TEXAS MEDICINE] Notice of Privacy Policies detailing how my information may be used and disclosed as permitted under federal and Texas Law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of personal medical information

_____
_____
_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed: _____ Date: _____

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: _____ Witnesses by: _____

Internal Use Only
If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below

Presented on (date and time) _____

By (name and title) _____

Processed by:

Name: _____ Date: _____
(Last Name, First Name)

Signature: _____