**FLOWER MOUND FAMILY PHYSICIANS**

**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES**

**Notice to Patient:**

We are required to provide you with a copy of our Notice of Privacy Practices, which states how

we may use and/or disclose your health information.

Please sign this form to acknowledge receipt of the Notice of Privacy Practices. You may refuse to sign this acknowledgement, if you wish.

**Acknowledgement:**

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

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*(Name of Patient)*

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*(Signature of Patient or Patient’s Representative) (Date)*

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*(Relationship to Patient)*

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| ***For Office Use Only:***  I attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices from the individual noted above, but it could not be obtained because:   * An emergency prevented us from obtaining acknowledgement * A communication barrier prevented us from obtaining acknowledgement * The individual was unwilling to sign * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   ­  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  STAFF MEMBER SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |