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| PLEASE COMPLETE THIS SECTION |

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

**Practice Name: BOERNE HEALTHCARE GROUP**

I acknowledge that I have been provided with a copy of the Practice’s Notice of Privacy Practices.

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Print Name Date of Birth

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Patient (or Patient Representative\*) Signature Today’s Date

For Practice Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

|  |  |
| --- | --- |
|  | Individual refused to sign |
|  | Communication barriers prohibited obtaining the acknowledgement |
|  | An emergency situation prevented us from obtaining acknowledgement |
|  | Other (Please specify) |

\*If the patient representative is signing, legal documentation must be included designating authority to sign or receive information. This form must be maintained for 6 years.