

University of North Texas Health Science Center at Fort Worth
Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of the medical practice's Notice of Privacy Practices.

Patient's Name: _____ Date of Birth: _____

Signed: _____ **Date:** _____

If not signed by the patient, please indicate relationship:

- parent or guardian of minor patient
- guardian or conservator of an incompetent patient
- beneficiary or personal representative of deceased patient
- Other: _____

Print Name of person signing form if not patient: _____

For Office Use Only:

Signed form received by: _____

Acknowledgement refused:

Efforts to obtain: _____

Reasons for refusal: _____

For additional information please contact our Institutional Privacy Officer at ext. 0404 or the Director of Regulatory Compliance at ext. 2571.