Patient Name: _____ **DOB:** _____ **MRN:** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Texas Oncology 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 the form 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 Oncology.

Patient Name (Please Print): _____

Signature of Patient/Legally Authorized Representative: _____

Date: _____

Relationship to Patient (if Patient not signing): _____

For patients requiring translation or verbal reading of this document, the person reading or translating should document and sign below:

Reader/Translator Signature: _____ Date: _____

Texas Oncology Use Only
Date Acknowledgement Received: _____

-OR-

Reason acknowledgment was not obtained:

_____

_____

_____

Please return completed form to the appropriate physician's office.