

## Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of the NORTH TEXAS MEDICAL-SURGICAL CLINIC, P.A. Notice of Privacy Policy, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

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I understand that as part of my treatment, the physicians at North Texas Medical-Surgical Clinic, P.A. may determine that I should visit a specialist, other physician, healthcare provider or provider of medical supplies and equipment. I authorize North Texas Medical-Surgical Clinic, P.A., for referral purposes, to release or disclose my protected health information as described in the **Notice of Privacy Policy**. Additionally, I understand that brief messages regarding reminders for appointments that are made or other necessary notifications such as processed referrals and completed laboratory testing, may be left on my personal or business answering device. I understand that when information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization at any time. Such revocation must be done in writing to the attention of the Privacy Officer and sent via Certified US mail or by facsimile.

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: \_\_\_\_\_

Printed: \_\_\_\_\_

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

Relationship: \_\_\_\_\_ Witnesses by: \_\_\_\_\_

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### 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): \_\_\_\_\_