Acknowledgement of Review of

Notice of Privacy Practices

I have been given the opportunity to review The Notice of Privacy Practices of Clinical OB/GYN Associates of Las Colinas, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this notice.

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Signature of Patient or Personal Representative

_____

Date

_____

Name of Patient or Personal Representative

_____

Relationship to Patient