Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Texas Avenue Medical Clinic's Notice of Privacy Policies, 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 information:

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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.

X Signed: ___________________________ Date: ___________________________

If not signed by patient, please indicate relationship to patient (ex. Spouse, parent)

Relationship: _______________________ Witnessed by: ____________________

Internal Use Only:

If patient or patient's representative refuses to sign acknowledgement of receipt 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): _______________________________