Austin Medical Associates
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Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices (can be found on the web site or for review in the office), which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document if so desired.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Printed Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority