

THE UNIVERSITY OF TEXAS
SOUTHWESTERN MEDICAL CENTER
AT DALLAS

Ambulatory Services

**Notice of Privacy Practices
Acknowledgement of Receipt Form**

Pt. Name: _____
Address: _____

City State Zip
MRN: _____
DOB: _____
SSN: _____ SEX: _____
DOS: _____

Your signature below indicates that you have been offered a copy of UT Southwestern's Notice of Privacy Practices. If you have any questions about the Notice of Privacy Practices, please call The UT Southwestern's Privacy Officer at 214-648-2000.

I have been offered the Notice of Privacy Practices.

Patient Signature Date

Print Patient Name Date

Legal Guardian or Patient Representative Signature Date

Print Legal Guardian or Patient Representative Name Date

Relationship to Patient Date

Please describe relationship to patient if other than self. _____

FOR OFFICE USE ONLY:

UT Southwestern will make a good faith effort to obtain a written acknowledgement of receipt of the Notice provided to the individual. If the patient is unwilling and or unable to sign this acknowledgment, UT Southwestern must document its good faith efforts to obtain such acknowledgement and record the reason why the acknowledgement was not obtained.

Reason: _____

Notice mailed to patient Date: _____ Staff Signature: _____