ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

DIAGNOSTIC PARTNERS OF NORTH TEXAS/MURPHY MEDICAL CLINIC

Patient Name: _____

Date of Birth: _____

I authorize physician & staff to treat me and also acknowledge that Diagnostic Partners of N. TX/Murphy medical Clinic provided me with a written copy of Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

_____ _____

Patient Signature Date

_____ _____

Patient's Representative Name in Print &Signature (if applicable) Relationship to Patient