

ACKNOWLEDGEMENT OF REVIEW

***NOTICE OF PRIVACY PRACTICES***

I have reviewed the ***Notice of Privacy Practices*** for Central Texas Surgical Associates, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

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Signature of Patient or Personal Representative

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Date Signed

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Patient or Personal Representative

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Description of Personal Representative’s Authority