



**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT/
INFORMATION RELEASE FOR INDIVIDUALS
INVOLVED IN PATIENT'S CARE**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have been given the opportunity to review the TexPTS "Notice of Privacy Practices". This document contains a description of the uses and disclosures of my healthcare information, and my rights regarding such information. TexPTS displays the "Notice of Privacy Practices" in each clinic's reception area.

I understand that TexPTS has the right to change its "Notice of Privacy Practices" and that if changes are made, a revised copy of the notice will be posted in the reception area. I also understand that if I have any questions, or wish to receive copies or a current copy of "Notice of Privacy Practices", I may contact:

Compliance Officer
Central Billing Office
8930 Four Winds Dr., Ste. 109
San Antonio, TX 78239
Phone: (888) 590-4002 Fax: (210) 590-4585

INFORMATION RELEASE FOR INDIVIDUALS INVOLVED IN PATIENT'S CARE

NAME	RELATIONSHIP

I do NOT wish to have my health information disclosed to the individuals below even though they are involved in my care.

NAME	RELATIONSHIP

If you are the representative of a patient, check the scope of your authority to act on the patient's behalf:

- Power of Attorney Guardian Surrogate Decision-Maker
 Executor of Legal Rep. Parent Other (please specify) _____

Provide documentation or explanation of your authority to act for the patient:

By signing this form I am acknowledging my understanding of the "Notice of Privacy Practices" and authorizing persons listed on the Information Release to receive or not receive my health information.

Signature of Patient (or Patient's Representative)

Date