Form 2052 – Acknowledgement of Notice of Privacy Practices

_____ _____
Patient Name Date of Birth

_____
Social Security Number

I have received a copy of HealthTexas Medical Group of San Antonio's Notice of Privacy Practices.

_____ _____
Signature of Patient or Personal Representative Date

I give HealthTexas Medical Group permission to speak with the following individuals regarding my personal health information:

Name: _____Relationship:_____

Name: _____Relationship: _____

Name: _____Relationship:_____

Patient or personal representative received a Notice of Privacy Practices but refused to sign above. After a good faith effort to obtain this acknowledgement I was unable to because:

_____

_____

_____

_____
Printed Name of Practice Associate

_____ _____
Signature of Practice Associate Date