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## **NOTICE OF PRIVACY PRACTICES: ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS**

By signing below, you acknowledge that you have received access to the *Notice of Privacy Practices* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

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### **SIGNATURES:**

Patient/Legal Representative:

\_\_\_\_\_ Date: \_\_\_\_\_  
(Signature)

Patient Name: \_\_\_\_\_  
(Please Print Name)

Patient Date of Birth: \_\_\_\_\_

If Legal Representative, relationship to Patient: \_\_\_\_\_

Witness (optional): \_\_\_\_\_ Date: \_\_\_\_\_