



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

PATIENT NAME (PLEASE PRINT)

I have received the Notice of Privacy Practices of Denton Colon & Rectal Surgery, PA, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document for my records.

Signature of Patient or Patient's Representative

Date

Printed Name of Above Signature

Relationship to Patient of Signed by a Representative

Denton CRS Witness