Acknowledgment of Receipt of Privacy Notice

I acknowledge that I have read and understand all five sections of the Notice of Privacy Practices and am entitled to a copy for my own records if requested below.

(check applicable box)

❒ I DO wish to receive a copy of the Notice of Privacy Practices for my records

❒ I DO NOT wish to receive a copy of the Notice of Privacy Practices for my records

_____ _____

Print name of patient **Relation to patient**

_____ _____

Patient or legally authorized individual **Date**

By entering your name and/or initials, you electronically acknowledge carefully reading, understanding and agreeing to the above office policies and procedures. In addition, you will provide an in-person signature when you arrive at our office.

Phone: 469-547-1173
Office@DrAmberBrooks.com
www.DrAmberBrooks.com

DR. AMBER BROOKS
THE MISSING PIECE IN YOUR CHILD'S TREATMENT