DFW Pediatric Neurology

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name _____

Date of Birth _____

Social Security Number _____

I acknowledge that DFW Pediatric Neurology provided me with a written copy of his/her Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

_____ _____

Patient Signature Date

_____ _____

Personal Representative Signature (if applicable) Relationship to Patient