

REYNOSO MD MEDICAL CENTER, LLC

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**Acknowledgment of Receipt of Privacy Notice**  
(Original to be maintained in patient's permanent medical record)

I acknowledge that the office's Notice of Privacy Practices has been made available to me.

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Patient or Legally Authorized Individual Signature

Date

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Printed Name if signed on behalf of the patient

Relationship to Patient

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**CONTACT INFORMATION**

I may be contacted in the following manner (circle all that apply):

- OK to leave message with detailed information :      Home    Work    Cell    NO
- OK to leave call-back number only:                      Home    Work    Cell    NO
- OK to send mail to:    Home    Work    Cell    NO
- OK to Fax to:    Home    Work    Cell    NO

Those who may receive information regarding me:

\_\_\_\_ Spouse      Name of Spouse and birthdate: \_\_\_\_\_  
\_\_\_\_ Other      Name and birthdate: \_\_\_\_\_  
\_\_\_\_ Other      Name and birthdate: \_\_\_\_\_

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Patient Signature

Date