

Patient Name _____

Date of Birth _____



William A. Paruolo, M.D.,P.A.
6053 Main Street Suite 225
The Colony, TX 75056

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed the Notice of Privacy Practices that was provided to me by William A. Paruolo, M.D., P.A. which explains how the above named patients' medical information will be used and disclosed. I understand that I am entitled to receive of copy of this document.

Signature of Parent or Guardian

Date

Name of Parent or Guardian

Description of Personal Representative's Authority (ie; Mother, Father)