



*Texas Fertility Center*

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**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I acknowledge that Texas Fertility Center provided me with a written copy of its 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