AUSTIN FERTILITY SURGERY CENTER

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