CLINICALNEUROPSYCHOLOGY
OF TEXAS

Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this sheet indicate that you have been given the opportunity to review and request a copy of Clinical Neuropsychology of Texas's Notice of Privacy Practices (Notice) on the date indicated. If you have any questions regarding the information in Clinical Neuropsychology of Texas's Notice of Privacy Practices, please do not hesitate to contact Dr. O'Rourke.

Patient Name (Printed):

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If Patient Representative, Name (Printed):

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If Patient Representative, Relationship to Patient (Printed):

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Signature:

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Date Notice Received:

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