WICHITA FALLS ENDOSCOPY CENTER, LLC
1500 9TH STREET, WICHITA FALLS, TEXAS 76301
PHONE: (940) 761-9034
FAX: (940) 761-7510

HIPAA Privacy Receipt Acknowledgement

Wichita Falls Endoscopy Center Notice of Privacy Practices has been provided to me. I understand that I have the right to review The Notice of Privacy Practices prior to signing this document and by signing this document, acknowledge only that I have received Wichita Falls Endoscopy Center Notice of Privacy Practices. The Notice of Privacy Practices for Wichita Falls Endoscopy Center is also provided at the front desk of Wichita Falls Endoscopy Center.

Printed Name of Patient: _____

Signature of Patient: _____

Date: _____

OR

Printed Name of Personal Representative: _____

Signature of Personal Representative: _____

Description of Authority of Personal Representative: _____

Date: _____

The above-named patient or personal representative of the patient was given Wichita Falls Endoscopy Center's Notice of Privacy on the data indicated, but either refused to sign the acknowledgement or did not return the acknowledgement.

_____ _____

Signature of Wichita Falls Endoscopy Center Staff Member Date