

**F3.2B**

**North Texas Family Medicine  
1340 Highway 377 N, Suite 110  
Pilot Point, TX 76258  
Phone: (940) 686-0860**

**Notice of Privacy Practices Receipt**

I acknowledge that I was provided with the Notice of Privacy Practices of North Texas Family Medicine.

**Print Name of Patient:** \_\_\_\_\_

**Signature of Patient:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Patients Date of Birth:** \_\_\_\_\_

**For Personal Representative of the Patient(if applicable)**

**Print Name of Person  
Representative:** \_\_\_\_\_

**Describe Personal Representative  
Relationship:** \_\_\_\_\_

**Signature of Personal  
Representative:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Signature of Practice**

**Employee:** \_\_\_\_\_

**Date:** \_\_\_\_\_