



**VALLEY INTENSIVISTS, PULMONOLOGISTS AND
SLEEP SPECIALISTS**

1200 E. Savannah Ave. Suite 12
McAllen, TX 78503
Tel: (956) 688-6300 Fax: (956) 688-6303

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been offered a copy of Valley Intensivists, Pulmonologists and Sleep Specialists' Notice of Privacy Practices, which describes how my health information may be used and disclosed.

I understand that I have the right to request and receive a copy of this Notice at any time.

Patient Name: _____

Signature

Signature of Patient or Personal Representative: _____

Date: _____

If Signed by Personal Representative

Name of Personal Representative: _____

Relationship to Patient: _____

Description of Authority (e.g., parent, legal, guardian, POA): _____

FOR OFFICE USE ONLY

If acknowledgement is not obtained, please document reason:

- Patient refused to sign
- Patient unable to sign
- Emergency situation
- Other: _____

Staff Initials: _____

Date: _____