# DURANGO REPRODUCTIVE MEDICINE

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## Notice of Privacy Practices Acknowledgement

Patient Name: _____

We keep a record of the health care services we provide to you. You have the right to see and receive a copy of that record. You may ask to amend that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes us or compels us to do so. You may see your record or get more information about it by contacting Karen or Tawnya.

The Notice of Privacy Practices document describes in detail how your health information may be used or disclosed. You have been given the opportunity to read the complete Notice of Privacy Practices document and you may have a copy of the Notice of Privacy Practices document. The Notice of Privacy Practices document is available online on our website, www.durangoreproductive.com.

**By my signature below I acknowledge I have been made aware of the Notice of Privacy Practices.**

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Patient or legally authorized individual signature date time

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Printed Name if signed on behalf of patient relationship of signer