



**ORTHOPEDIC CLINIC OF  
GALVESTON COUNTY ASSOCIATES**

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**NOTICE OF PRIVACY PRACTICES  
ACKNOWLEDGMENT RECEIPT**

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

**Patient's Date of Birth:** \_\_\_\_\_

**Last Four Numbers of Soc. Security:** \_\_\_\_\_

I acknowledge that I have been provided a copy of Orthopedic Clinic of Galveston County Associates' Notice of Privacy Practices.

\_\_\_\_\_  
Signature of Patient (or Personal Representative)

\_\_\_\_\_  
Date

\*\*\*\*\*

I acknowledge that I declined a copy of Orthopedic Clinic of Galveston County Associates' Notice of Privacy Practices provided:

\_\_\_\_\_  
Signature of Patient (or Personal Representative)

\_\_\_\_\_  
Date