Rio Grande Medicine
Caring. For life.

ACKNOWLEDGMENT AND REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I agree to the terms listed as proper security and privacy of my protected health information. I understand that I am entitled to receive a copy of this document.

_____ _____

Signature of Patient / authorized representative Relationship to patient Date

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