Acknowledgement of Receipt of Notice of Privacy Practices

My signature below signifies that **Cypress Physicians Association**'s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations of the Cypress Physicians Assoc. The Notice of Privacy Practices for Cypress Physicians Assoc. is also provided at the front desk. This Notice of Privacy Practices also describes my rights and Cypress Physicians Assoc.'s duties with respect to my protected health information.

Signature of Patient	Patient's Personal Representative
Name of Patient	Name of Patient's Personal Representative
Date	Description of Patient's Personal Representative's Authority