Patient Name: _____
Patient DOB: _____


Our Lady of the Lake Physician Group
Lourdes Physician Group
St. Francis Medical Group

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

By signing below, I acknowledge that I have been provided access to the Notice of Privacy Practices, and fully understand and accept its terms and conditions. I have had a chance to ask any questions that I might have. Please note that healthcare providers have the right to disclose protected healthcare information to a minor's parent/guardian should he/she deem necessary.

**Patient Name (print):** _____

**Patient Signature:** _____

**Date:** _____ **Time:** _____

As the representative of the patient, I acknowledge that I have been provided access to the Notice of Privacy Practices, and fully accept its terms and conditions on his/her behalf.

**Legal Guardian Name (print):** _____

**Legal Guardian Signature:** _____

**Relationship to Patient:** _____

**Date:** _____ **Time:** _____