South Austin Oral Surgery – Notice of Privacy Practices

Acknowledgement of Review

Date: _______________

I have reviewed the South Austin Oral Surgery (SAOS) Privacy Practices (version effective December 1, 2022), which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this notice if requested.

____	____
Patient Name (Printed)	Patient Signature

If completed by a patient's personal representative, please indicate your relationship to the patient and print and sign your name in the space below.

____

Relationship to Patient (Print)

____	____
Personal Representative (Print)	Personal Representative Signature