Primary Medicine of Sunnyvale

Below is a standard, legally compliant **HIPAA Privacy Notice Acknowledgment Form** tailored for a private clinic in Texas. This form meets both federal HIPAA requirements and the stricter privacy rules under the **Texas Medical Records Privacy Act** (Texas Health and Safety Code Chapter 181).

Notice of Privacy Practices: Patient Acknowledgment Form
We are required by law to maintain the privacy of your Protected Health Information (PHI) and to provide you with a notice of our legal duties and privacy practices.

1. Acknowledgment of Receipt
By signing below, you acknowledge that you have been made aware of, or have received a copy of, **Primary Medicine of Sunnyvale**'s Notice of Privacy Practices. This notice outlines how your medical information may be used and disclosed, and how you can get access to this information.

2. Texas State Law Enhancements (Chapter 181)
In accordance with Texas state law, we maintain enhanced security protocols for your electronic health records.

- **No Unauthorized Sale:** Your electronic health records will never be sold or disclosed for marketing purposes without your explicit, separate written authorization.
- **Employee Training:** All staff members at our facility undergo mandatory, regular training regarding the protection and privacy of patient records.

3. Communication Preferences
To assist with your care, please check the boxes below to indicate how we may communicate with you regarding appointments, billing, or clinical results:

- You may leave a detailed voicemail on my phone number: (__) -
- You may send secure text reminders to my mobile number: (__) -
- You may discuss my medical information /billing information with the following designated family member(s) or representative(s):
    - **Name:** _____ **Relationship:** _____
    - **Name:** _____ **Relationship:** _____

Patient Signature and Authorization
By signing below, I acknowledge receipt of the Notice of Privacy Practices and agree to the communication preferences outlined above.

Patient Name (Printed): _____
Date of Birth: _____
Patient Signature: _____
Date: _____
(If signed by a Legal Representative or Guardian, please state relationship to patient):
Representative Name: _____ **Relationship:** _____