ALBRACHT
ORTHOPEDIC SURGERY

**Acknowledgement of Notification of Health Information Practices**

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I, _____, acknowledge that, consistent with the Health Information Portability and Accountability Act of 1996 (HIPAA), I have been provided with a written copy of the health information practices of Albracht Orthopedic Surgery.

_____ _____
Signature of Patient or Person Authorizing Medical Treatment

Date

1901 Medi-Park Drive
Suite 103
Amarillo, TX 79106
806-24BONES
806-242-6637