Trilogy Women's Health, P.A.

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Acknowledgement of Review of Notice of Privacy Practices

| I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document. |
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| Signature of Patient or Personal Representative |
| Signature of Fatient of Fersonat Representative |
| Date |
| Name of Patient or Personal Representative |
| Description of Personal Representative's Authority |