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Notice of Privacy Practices Acknowledgement

I have received, read and understand your Notice of Privacy Practices containing a complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

Patient Name _____

Patient/*Guardian Signature if under 18* _____

Guardian Name *if applicable* _____

Relationship to patient _____

Date _____

Office Use Only

I attempted to obtain the patient/guardian's signature in acknowledgment of this Notice but was unable to do so as documented below:

Date:

Initial:

Reason:
