

DR.
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**ACKNOWLEDGEMENT OF RECEIPT OF CONSENT FORM
AND
NOTICE OF PRIVACY PRACTICES**

Patient Name (print): _____

Parent/Guardian Name (print): _____

Our office does not use encrypted email. If you give consent to communicate with this office via email, you do so with this knowledge. If you would like email communication with this office, please provide your email address below. Otherwise, you will receive all information and documents through the US mail or by phone

Email: _____

Mailing Address: _____

Your signature below indicates that you have read the Consent Form and Notice of Privacy Practices and understand their contents.

Signature Date _____ Patient

Or

Signature Date _____ Parent

Or

Guardian Signature Date _____ Legal

Legal Guardian Relationship to Patient