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**Acknowledgement of Review of  
Notice of Privacy Practices (HIPAA)**

I, \_\_\_\_\_ have received a copy of Dr. Kenneth W. Hollis, M.D.'s Notice of  
Patient Name  
Privacy Practices for review which explains how my medical information will be used, disclosed and protected.

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_

HIPAA Compliance Officer's Name: Beth Kramer

HIPAA Compliance Officer's signature: Beth Kramer

**Patient Record of Disclosures**

The HIPAA Privacy Rules gives individuals the right to request a restriction on uses and disclosures of their protected health information. The individual is also provided the right to request confidential communications or that a communication of health information be made by alternate means, such as sending correspondence to the individual's home or calling an individual at their workplace.

I wish to be contacted about my health information in the following manner(s):

Home telephone: \_\_\_\_\_ okay to leave message with detailed information,  
\_\_\_\_\_ leave message with callback number only.

Work telephone: \_\_\_\_\_ okay to leave message with detailed information,  
\_\_\_\_\_ leave message with callback number only.

Written communication: \_\_\_\_\_ okay to mail information to home address.

**Health Information may also be given to the following person:**

Name: \_\_\_\_\_ Telephone No.: \_\_\_\_\_

\_\_\_\_\_ okay to leave detailed message with the above person.  
\_\_\_\_\_ leave message for the above person with callback number only.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_