



Clinical Care Associates

Wise Regional Health System

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Acknowledgment of Patient Responsibilities

I have read the NOTICE OF PATIENT RESPONSIBILITIES and have had any questions answered by this office. I understand that by signing this form I acknowledge that I have read the Patient Responsibilities Notice.

My consent is freely given. I understand that I may revoke this consent at any time if that revocation is in writing, but any disclosures given in reliance on this prior consent will be permissible.

Patient's Name (printed)

Date

Patient's Signature (or guardian, if a minor)

Date

Witness (Optional)

Date