Medical History:

	Alcoholism		Cognitive Impairment		Kidney Disease
	Allergies/Hayfever		DVT		Kidney Infections
	Anemia		Depression		Kidney stone
	Anxiety		DM Type 1		Migraines
	Asthma		DM Type 2		Multiple Sclerosis
	Atrial Fibrillation		Epilepsy		Myocardial Infarction
	Blood Transfusions		Fracture		Obesity
	CAD		Gastric ulcer		Osteoarthritis
	Cancer		Gastrointestinal Disease		Osteoporosis
	Chemotherapy Treatment Date: ___________		Gastroesophageal Reflux Disease		Pneumonia
	Radiation Treatment Date: ___________		Gestational Diabetes		Progressive Neurological Disorder
	Cardiac Pacer		Glaucoma		Prostate Cancer
	Cardiovascular Disease		Heart Murmur		Pulmonary Disease
	CHF		Hepatitis		Rheumatic Fever
	Chicken Pox		High Cholesterol		Rheumatoid Arthritis
	Chronic Renal Failure		Hyperlipidemia		Shingles
	Cirrhosis		Hypertension		STD
	Colitis		Hyperthyroidism		Terminal Illness
	COPD		Hypothyroidism		Thyroid Disease
	COVID-19		Insulin Pump		TIA
	Crohn's disease		Joint Pain		Tuberculosis
	CVA		Left Ventricular Systolic Dysfunction		Valvular Problems

Hospitalizations:

Dates	Hospital Name	Reason

Smoking Status:

☐ Current every day smoker	☐ Current some day smoker
☐ Heavy tobacco smoker	☐ Light tobacco smoker
☐ Former smoker	☐ Never smoker

Family History: ☐ Adopted ☐ Unknown History

Mother/ Father	Condition	Mother/ Father	Condition	Mother/ Father	Condition
	Alcoholism		Congenital Anomaly		Kidney Disease
	Alzheimers		COPD		Liver Disease
	Anemia		Crohn's Disease		Multiple Births
	Anxiety		Depression		Multiple Sclerosis
	Asthma		Diabetes		Osteoarthritis
	Birth Defects		Epilepsy		Osteoporosis
	CAD		GERD		Pulmonary Disease
	Cardiovascular Disease		Hypercholesterolemia		Stroke
	CHF		Hyperlipidemia		Substance Abuse
	Cancer - Type: ____________________		Hypertension		
			Hypothyroidism		

Do you have any of the following?

Advanced Directive:	☐ Yes ☐ No	Living Will:	☐ Yes ☐ No
Medical Power of Attorney:	☐ Yes ☐ No	Do Not Resuscitate:	☐ Yes ☐ No

*Copy Received: Initials: ________________________ Date: _____________________ Time: __________________

Wound History:

Wound Location:		Start Date:	
Has it ever healed and reopened?	☐ Yes ☐ No	Who has been treating wound?	
Labs done in the past month?	☐ Yes ☐ No	Who ordered labs?	
Tested positive for antibiotic resistant organism (MRSA, VRE)?	☐ Yes ☐ No	Date:	
Tested positive for osteomyelitis (bone infection)?	☐ Yes ☐ No	Date:	
Have you had any tests for circulation on legs?	☐ Yes ☐ No	Where performed?	
Any other problem associated with the wound?	☐ Infection ☐ Swelling ☐ Other:		

How did the wound start?

	Bite		Chemical Burn		Other Lesion		Surgical
	Blister		Footwear		Pimple		Thermal Burn
	Bruise		Frostbite		Pressure		Trauma
	Bump		Gradually Appeared		Radiation Burn		Unknown

Allergies:

1. .____

2. .____

3. .____

4. .____

List of Medications

1.____

2. .____

3. .____

4. .____

5. .____

6. .____

7. .____

8. .____

9. .____

10. .____

11. .____

12. .____

13. .____

14. .____

15. .____

List of Doctors and phone numbers

1. .____

2. .____

3. .____

4. .____

5. .____

PATIENT'S NAME:___________________________

REVIEW OF SYSTEMS	Y	N		Y	N		Y	N
GENERAL			STOMACH			NEUROLOGICAL		
Headache			Trouble swallowing			Stroke		
Lethargy/Weakness			Heartburn/Indigestion			Seizures		
Chills/Night sweats			Change in bowel habits			Head injury		
Fever			Loose Stool/diarrhea			Memory loss		
Fainting spells/unconscious			Black/Bloody Stools			Confusion		
Weight loss			Frequent stomach pain			Trouble speaking		
Dizziness			Vomiting blood			Trouble swallowing		
EYES			Constipation			Unsteady gait		
Wears glasses			Irritable bowel			Trouble walking		
Eyesight worsening			Ulcers			Arm/leg weakness		
Double vision			Stomach/bowel cancer			Arm/leg tingling		
Eye pain			KIDNEY PROSTATE			Arm/leg numbness		
EARS/NOSE/THROAT			Frequent voiding			PSYCHIATRIC		
Deafness			Burning on urination			Nervous breakdown		
Noise in ears			Pus/blood in urine			Panic attacks		
Congestion/sneezing			Trouble starting urination			Cry often/depressed		
Sinus trouble/hay fever			Dribble with cough/sneeze			Worry a lot		
Nose bleeds			Loss of urine control			Considered suicide		
Sore throat or tongue			Prostate disease/cancer			Loss of interest in eating		
Hoarse voice			Sexual difficulty			Anxiety/tension		
Dental problem			SKIN			Loss of energy/fatigue		
HEART			Rashes			ENDOCRINE		
Chest pain with exertion			Birthmarks			Unwanted weight change		
Heart attack			Sores			Change in skin		
Heart murmur			Dry/oily skin			Breast discharge		
Heart racing/palpitations			Hair growth/loss			Excessive thirst		
Irregular heart beat			MUSCLE/BONE			Excessive tiredness		
Mitral valve prolapsed			Back pain			BREAST/MENSTRUAL		
High blood pressure			Neck pain			Endometriosis		
Swollen feet/ankles			Back surgery			Are you pregnant?		
Heart valve replacement			Arthritis			Irregular menstrual period		
Atrial fibrillation			Fibromyalgia			Breast discharge		
LUNG			Aching muscles/joints			Lumps in breast		
Lung cancer			Shoe lift or brace			SLEEP		
Shortness of breath			Bone/joint injury			Dreams/sleep walk		
Chest pain			Osteoporosis			Legs twitch		
Coughing up phlegm			HETATOLOGIC			Insomnia		
Cough up blood			Blood disease			Daytime drowsiness		
Wheezing/cough			Enlarged glands			Snores		
Pneumonia			Bleed/bruise easily			Breath holding/gasping		
			Anemia/low blood			Restless sleep		

Central Texas Wound Healing Associates

Written Consent: Consent to do Procedure, Anesthetics, and Other Medical Services

I, ___________________________________ authorize the performance of the following Procedure(s) If necessary:

- Wound debridement with curette
- Tissue culture
- Wound debridement with Ultrasound
- Application of compression wraps
- Biopsy
- Skin substitute
- Other __________

1. I consent to the performance of procedures in addition to or different from those completed, whether or not arising from presently unforeseen conditions, which the above-named doctor or his associate or assistants may consider necessary or advisable in the course of the procedure.
2. I consent to the performance of wound debridement with curette or MIST to be done on a weekly basis for duration of wound in order to help remove devitalized tissue or bioburden.
3. I consent to the performance of compression wraps done at least once a week sometime twice a week to help manage swelling to leg.
4. I consent to application of skin substitutes applied weekly to help achieve wound closure.
5. I consent to the administration of such anesthetics as may be considered necessary or advisable by the provider responsible for the service.

6. I consent to the photographing or television of the procedures to be performed, including appropriate portions of my body for medical, scientific or educational purposes.

7. For the purpose of advancing medical education, I consent to the admittance of observers to the procedure room.

8. The nature and purpose of the procedure, the possible alternative methods of treatment, the risks involved, the possible consequences and the possibility of complications have been explained to me by ____. This explanation has been explained to me in a non-medical language in which I understand. I further acknowledge that the procedure is an elective, non-emergency type of therapy/surgery and that I have thought over all the information that has been given to me.

9. I acknowledge that no guarantee or assurance has been given by anyone as to the results that may be obtained. Although an excellent result is expected, the possibility of complications could arise. Risks of this procedure include, but are not limited to:

a. Swelling	b. Disability	c. Delayed Healing	m. Hematoma
d. Extended Discomfort	e. No improvement	f. Blood Clot	n. Local anesthetic toxicity
g. Medication Reaction	h. Injury	i. Infection	o. Nerve damage
j. Numbness	k. Excessive bleeding	l. Joint stiffness	p. Paralysis

The above has been explained to me in non-medical terms.

I acknowledge that all blank spaces on this document have been either completed or crossed off prior to my signing.

___________________ ______________________________ ______

Witness Patient Date

__________________ _____________________ ___________________

Emergency Contact Emergency Contact phone Alternative Phone

Release of Medical Records Form
Central Texas Wound Healing Associates
540 Madison Oak Dr Suite 130
San Antonio Tx 78258

Patient Information:

- **Patient Name: ____________________________**
- **Date of Birth: ____________________________**
- **Address: __________________________**
- **City, State, Zip Code: ___________________**

I, the undersigned, authorize Central Texas Wound Healing Associate to release my medical records as follows:

- **Records to be Released:**
  - ☐ Complete Medical Record
  - ☐ Specific Records (please specify): ______________________________________
- **Purpose of Release:**
  - ☐ Continuation of Care
  - ☐ Personal Use
  - ☐ Legal
  - ☐ Other (please specify): ______________________________________

Recipient Information:

- **Name of Recipient: ____________________________**
- **Address: __________________________**
- **City, State, Zip Code: ___________________**
- **Phone Number: ____________________________**

Expiration of Authorization:
This authorization will expire on the following date: ____________________________
(If no date is specified, this authorization will expire one year from the date signed.)

Patient Rights:

- I understand that I have the right to revoke this authorization at any time by providing written notice to Central Texas Wound Healing Associates.
- I understand that my records may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

Signature:
By signing below, I acknowledge that I have read and understood this Release of Medical Records form and voluntarily authorize the release of my medical records as specified above.

Patient Signature: ______________________________
Date: ______________________________
If signed by a representative:

- **Name of Representative: ______________________________**
- **Relationship to Patient: ______________________________**
- **Signature of Representative: ______________________________**
- **Date: ______________________________**

HIPAA Notice of Privacy Practices - Sample Notice

Disclaimer: Template Notice of Privacy Practices (45 C.F.R. § 164.520)

The information provided in this document does not constitute, and is no substitute for, legal or other professional advice. Users should consult their own legal or other professional advisors for individualized guidance regarding the application of the law to their particular situations, and in connection with other compliance-related concerns.

To customize this template document, replace all of the text that is presented in brackets (i.e., "[" and "]") with text that is appropriate to your organization and circumstances. After completing the customization of this document, the document should be reviewed by an attorney who is familiar with health privacy laws and regulations in the state(s) in which the organization maintains its offices or facilities, and who is in a position to provide legal counsel to your organization.

[Note: The Notice should be completed based on the organization's actual practices, which must be documented in policies and procedures. Thus, a physician practice must have completed its policies and procedures regarding uses and disclosures, authorizations and consents, inspection and copying, accounting, alternative methods for giving information to patients, amendments, changes in the Notice and restrictions of uses and disclosures prior to finalizing this Notice.

In determining their participation in organized health care arrangements (OHCA), as set forth in Section A.3, physicians should generally list: (1) every hospital where they have staff privileges; (2) every IPA with which they participate; (3) every health plan with which they contract; and (4) any other organization that has informed the physician that the physician is an OHCA participant.

In addition, each patient right described in Section C below should be explained in enough detail so that the individual understands that each right is not absolute and is subject to some limitations and conditions. While some of these rights have been expanded to include the basic limitations provided under the law, each should be considered in light of the organization's actual practices.]

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NOTICE OF PRIVACY PRACTICES

45 C.F.R. § 164.520

[Central Texas Wound Healing Associates]

Heather Aguirre (210-346-1550)

Effective Date:[August 28, 2025]

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

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A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart [and on a computer][and in an electronic health record/personal health record]. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. [*Participants in organized health care arrangements only should add*: We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.]

4. [Optional]: Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this

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information on your answering machine or in a message left with the person answering the phone.]

5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect;

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reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.

18. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

19. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be

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transferred to another physician or medical group.

21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate. [Note: Only use e-mail notification if you are certain it will not contain PHI and it will not disclose inappropriate information. For example if your e-mail address is "digestivediseaseassociates.com" an e-mail sent with this address could, if intercepted, identify the patient and their condition.]

22. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records

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or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will

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be available at each appointment.

Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

- Call: 1-888-388-6332 or 512-438-4313
- Email: HHSCivilRightsOffice@hhs.texas.gov
- Fax: 512-438-5885
- Mail:
  Civil Rights Office
  Health and Human Services Commission
  P.O. Box 13247, Mail Code: 1560
  Austin, Texas 78711

OCRMail@hhs.gov

The complaint form may be found at **www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf**. You will not be penalized in any way for filing a complaint.

HIPAA Privacy Notice Acknowledgment

Central Texas Wound Healing Associates
540 Madison Oak Dr. Suite 130
San Antonio, TX 78258

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Patient Information:

- **Patient Name: ______________________________**
- **Date of Birth: ______________________________**
- **Patient Address: ____________________________**
- **City, State, Zip Code: ____________________**

Acknowledgment of Receipt of Notice

I, the undersigned, acknowledge that I have received and reviewed the HIPAA Privacy Notice from Central Texas Wound Healing Associates. I understand that this notice describes how my medical information may be used and disclosed, as well as my rights regarding my protected health information.

I understand that I can request a copy of the HIPAA Privacy Notice at any time.

Patient Signature: ______________________________

Date: ______________________________

If signed by a personal representative of the patient:

- **Name of Personal Representative: ______________________________**
- **Relationship to Patient: ______________________________**
- **Signature of Personal Representative: ______________________________**
- **Date: ______________________________**

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