

**International Health Services  
7500 W. Camp Wisdom Rd  
Dallas, TX 75236  
Phone: 972-708-7408**

**RECEIPT OF NOTICE OF PRIVACY PRACTICES  
Written Acknowledgement Form**

I, \_\_\_\_\_, have had the opportunity to  
*printed name (of patient if 18 years or older, or responsible party)*

review a copy of the International Health Services Notice of Privacy Practices.

\_\_\_\_\_  
*signature*

\_\_\_\_\_  
*date*