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Acknowledgment of Receipt of Notice of Health Information Practices

I have been offered a copy of Moscow Family Medicine’s Notice of Health Information Practices, which describes how my health information is used and shared. I understand that Moscow Family Medicine has the right to change this notice at any time. I may obtain a current copy by asking a receptionist, or by visiting Moscow Family Medicine’s website at www.MoscowFamilyMedicine.com

 Patient Name

 Signature

 Today’s Date

 Social Security Number

 Signature of legal representatives or
 next of kin, if applicable

 Relationship (if signed by other than patient)

Other family members under age 18 for whom I acknowledge Receipt of these policies:

Patient Name

Date of Birth

I authorize you to discuss my health status and care with the following parties. This authorization will continue force until I revoke it in writing. I understand that information released in this manner may be subject to re-disclosure by the recipient.

Authorized Party	Social Security Number	Relationship to Patient
1.		
2.		
3.		
4.		
5.		