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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](http://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

\_\_\_\_\_  
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