LMG LOUDOUN MEDICAL GROUP
One Group. Infinite Possibilities.

Digestive Disease Physicians
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Receipt of Notice of Privacy Practices Acknowledgement

In addition to releasing my protected health information to health care providers for treatment and/or payment, you may also discuss and/or release health care information/medical records to:

NAME: _____ **RELATION(S):** _____ **PHONE #:** _____

NAME: _____ **RELATION(S):** _____ **PHONE #:** _____

NAME: _____ **RELATION(S):** _____ **PHONE #:** _____

□ I do **not** wish my information/records to be released to anyone but my physician(s)

I, _____ acknowledge receiving on

_____(date), a copy of Loudoun Medical Group's Notice of Privacy Practices.

_____

Patient signature

FOR OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Receipt of Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Staff Initials	Reason
		Refused to sign (circle if applicable) **Other:**