LOUDOUN MEDICAL GROUP

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).

Receipt of Notice of Privacy Practices Acknowledgement

____
Patient's Name

I have received a copy of Loudoun Medical Group's Notice of Privacy Practices and understand that the notice describes how my/the patient's medical information may be used and how access to this information may be obtained. I have also been given an opportunity to ask questions about the information provided in the Notice.

____
Signature
Date: _____________________________

____
Relationship to patient (if Acknowledgement Form is executed by someone other than the Patient)

FOR OFFICE USE ONLY

I attempted to obtain the patient's/representative'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:**