
**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**
**Nova MFM**

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**Patient Name: _____**

**Date of Birth: _____**

**Address: _____**

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**Phone Number: _____**

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I acknowledge that I have received a copy of Nova MFM's Notice of Privacy Practices. This Notice explains how my medical information may be used and disclosed, as well as my rights regarding my health information under federal and Washington State law.

I understand that I may request a copy of the Notice at any time.

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**Patient Signature: _____**

**Date: _____**

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**If signed by personal representative:**

**Name of Representative: _____**

**Relationship to Patient: _____**

**Signature: _____**

**Date: _____**

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**For Office Use Only (if patient refuses or is unable to sign):**

☐ Patient refused to sign

☐ Patient unable to sign

**Reason: _____**

**Staff Name: _____**

**Staff Signature: _____**

**Date: _____**

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