MEDICAL FACULTY ASSOCIATES
THE GEORGE WASHINGTON UNIVERSITY

AKNOWLEDGEMENT FORM
NOTICE OF PRVACY PRACTICES

By signing this form, you acknowledge that you have received the Notice of Privacy Practices for The George Washington University Medical Faculty Associates ("MFA") which describes MFA's use and disclosure of your individually identifiable health information and your rights with respect to this information.

If you refuse to sign this form but receive health care services, you have implicitly consented to MFA's use and disclosure of your individually identifiable health information as described in our Notice of Privacy Practices.

Patient's Signature: ____

Patient's Name (printed): ____

Date: ______________________________

If patient is unable/unwilling to acknowledge receipt or is a minor, complete the following:

Patient is: __________ a minor

__________ unable

__________ unwilling

Signature of Personal Representative (if applicable):______________________________

Personal Representative's Name (print):______________________________________

Relationship to Patient: ____

Medical Record Number (for employee use only): ______________________________