# MORE MD
## Acknowledgement of Notice of Privacy Practices

By signing this form, you acknowledge receipt of the Notice of Privacy Practices from MORE MD. The Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to review it carefully. The Notice of Privacy Practices is subject to change. If the notice is changed, you may obtain a revised copy by visiting our website at MOREMD.NET or on request from our staff.

I acknowledge receipt of the Notice of Privacy Practices from MORE MD.

Signature: _____ Date: _____
(Patient / Parent / Guardian/ MPOA)

Name: _____ Date of birth: _____