Momentum Medicine Plus LLC

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that Momentum Medicine Plus LLC, has provided me with a copy of the Notice of Privacy Practice as required by the Health Insurance Portability and Accountability Act of 1996. I certify that I am the patient or the patient's representative.

_____	_____	____/____/___
Name of Patient	**Signature of Patient**	**Date**
_____	_____	____/____/___
Name of Patient's Representative	**Signature of Patient's Representative**	**Date**

I decline to review the Notice of Privacy Practices Acknowledgement, which was offered for my review as required by the Health Insurance Portability and Accountability Act of 1996. I certify that I am the patient or the patient's representative.

_____	_____	____/____/___
Name of Patient	**Signature of Patient**	**Date**
_____	_____	____/____/___
Name of Patient's Representative	**Signature of Patient's Representative**	**Date**