

# 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.

_____	_____	____/____/____
<b>Name of Patient</b>	<b>Signature of Patient</b>	<b>Date</b>
_____	_____	____/____/____
<b>Name of Patient's Representative</b>	<b>Signature of Patient's Representative</b>	<b>Date</b>

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.

_____	_____	____/____/____
<b>Name of Patient</b>	<b>Signature of Patient</b>	<b>Date</b>
_____	_____	____/____/____
<b>Name of Patient's Representative</b>	<b>Signature of Patient's Representative</b>	<b>Date</b>