I certify that I have received Inova's **Notice of Privacy Practices** and that I have a right to receive an additional copy upon request. This Notice describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of Inova's health care operations. The Notice also describes my rights and Inova's duties with respect to my protected health information. I understand that copies of the **Notice of Privacy Practices** are available in the registration areas of each facility and on Inova's web site at www.inova.org. I may request that a copy be mailed to me by calling **571-472-8187.**

Inova reserves the right to change the privacy practices that are described in the **Notice of Privacy Practices**. I may obtain a revised **Notice of Privacy Practices** by calling the above number and requesting a revised copy be mailed to me, by asking for one at the time of my next appointment, or by accessing Inova's web site listed above to view the most current version.

______________________________ ______________ ______________

**Patient or Personal Representative** (signature) Date Time

______________________________

**Patient or Personal Representative** (print name)

______________________________

Description of Personal Representative's Authority

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: ______________________________

Date of Birth: ______________ Medical Record # ______________

**Inova**

## Acknowledgement of Receipt of Notice of Privacy Practices

☐ IAH ☐ IFH ☐ IFOH ☐ ILH ☐ IMVH

☐ Outpatient Location: ______________

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