

**Horizon Family Medical Group  
HIPAA NOTICE OF PRIVACY PRACTICES**

\*PLEASE RETURN TO RECEPTION TO FILE IN YOUR CHART\*

Yes      No

- I have read the Privacy Notice
  
- I have been offered a copy of the Privacy Notice
  
- I have requested a copy of the Privacy Notice
  
- I give permission to have information left on my answering machine
  
- I give permission to leave information with my family member(s)

Name(s) of family member(s):

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I acknowledge receipt of this notice:

**Name (print):** \_\_\_\_\_

**Sign:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If you are signing as the patient's representative:

**Name (print):** \_\_\_\_\_

**Describe your authority:** \_\_\_\_\_

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