



Moore for Women Healthcare & Wellness
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ACKNOWLEDGMENT

I hereby acknowledge receipt of the Notice of Privacy Practices.

Patient's Name:	Date of Birth:
Patient's Signature:	
Date:	Social Security Number:

If this acknowledgment is by someone other than the patient (a personal representative) please complete the following:

A personal representative is a person legally authorized to act on behalf of an individual for health care decisions, including, in most cases, a parent or court appointed guardian, executor or administrator.

Personal Representative's Name:

Personal Representative's Signature:

Relationship to Patient:

If unable to obtain written acknowledgment of receipt of the Notice of Privacy Practices document good faith efforts to obtain acknowledgment and the reason why the acknowledgment was not obtained below.

Signature **Healthcare** Staff Member: _____

Print Name: _____

Date: _____