
**Family Medical Center, P.A. – Little Falls
Community Medical Center - Pierz**

I acknowledge that I have been given a copy of the *HIPAA* Notice of Privacy Practices*.

Printed Name of Patient

Patient's Date of Birth

Signature of Patient or Legal
Representative

Date of Signature

Authority of signer if not the patient
(Parent, guardian, or other legal status)

* HIPAA stands for Health Insurance Portability and Accountability Act