



**The George Washington University  
Medical Faculty Associates**

**Acknowledgment Patient Was Provided  
Notice of Privacy Practices**

Patient Name: \_\_\_\_\_

MRN: \_\_\_\_\_

Date: \_\_\_\_\_

**I acknowledge I was given MFA's Notice of Privacy Practices today.**

\_\_\_\_\_  
[Patient Signature]

Witnessed by:

\_\_\_\_\_  
MFA Staff Member Name:  
Title:

\_\_\_\_\_  
If patient declines to sign, MFA staff member signs below to confirm that Notice was offered to patient on the date listed above and patient declined to sign acknowledgment.

\_\_\_\_\_  
MFA Staff Member Name:  
Title: