



Mossop Acupuncture

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Receipt of Notice of Privacy Practices

My signature below acknowledges I have read and understand the *Notice of Privacy Practices* for Mossop Acupuncture/Hannah Mossop, L.Ac.. I understand that this document provides an explanation of the ways in which my health information may be used and/or disclosed, and of my rights with respect to my health.

I have been provided with a copy of the *Notice of Privacy Practices* and have had the opportunity to discuss concerns I may have regarding the privacy of my health information.

Patient Name: _____ Date: _____

Patient (or Parent/Guardian) Signature: _____

Relationship to Patient: _____