



ASSOCIATES IN FAMILY
MEDICINE

8940 State Avenue
Kansas City, Kansas 66112-1646

PF-2000 Acknowledgment of Receipt of Notice of Privacy Practices

Associates in Family Medicine, P.A. reserves the right to modify the privacy practices outlined in the notice.

Signature

I have received a copy of the "Notice of Privacy Practices" for **Associates in Family Medicine, P.A.**.

Name of Patient (Print or Type)

Signature of Patient

Date

Signature of Patient Representative

(Required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient