

**LOUDOUN MEDICAL GROUP
D.B.A. LOUDOUN COMMUNITY MIDWIVES
RECEIPT OF NOTICE OF PRIVACY PRACTICES AGREEMENT**

I, _____, acknowledge receiving on
(print patient name)

_____, a copy of Loudoun Medical Group's Notice of Privacy Practices.
(print date)

(patient signature or initials)

Notice:

Loudoun Community Midwives are Certified Nurse Midwives. We are licensed in Virginia as Nurse Practitioners in the Certified Nurse-Midwife category. The physician who supervises our prescriptive authority is:

Virginia Hackenberg, M.D.,
19465 Deerfield Ave. Suite 205
Lansdowne, VA 20176
703-858-2811

FOR OFFICE USE ONLY:

I attempted to obtain the patient's signature in acknowledgement of this Receipt of Notice of Privacy Practice Acknowledgement, but was unable to do so as documented below:

Date	Staff Initials	Reason
		Refused to sign (circle if applicable) Other: