

**Koch Family Medicine, S.C.**

411 Maxine Dr.  
Morton, IL 61550  
309-263-2411

**NOTICE OF PRIVACY PRACTICES**

Patient Name (Print): \_\_\_\_\_

Date of Birth: \_\_\_\_\_

My signature certifies that I have been given or offered a copy of the **NOTICE OF PRIVACY PRACTICES.**

\_\_\_\_\_  
(Patient or Guardian Signature)

\_\_\_\_\_  
Date