

Acknowledgement of Receipt of Notice of Privacy Practices

Name: _____ MR#: _____

I understand that Dr. Sheila L. Patterson is a healthcare provider and may share my health information for treatment, payment and healthcare operations. I have been given a copy of the organization's Notice of Privacy Practices, which describes how my health information is used and shared. I understand that Dr. Sheila L. Patterson has the right to change this notice at any time. I may obtain a current copy by contacting the Privacy Officer at 919-834-4646, or printing it from the website: www.doctorsweightsolutions.com.

My signature below constitutes my acknowledgement that I have either
 been provided with a copy of the Notice of Privacy Practices, or
 do not wish to have a printed copy, since it is available to read and print on the website.

If any person is physically unable to provide a signature OR signs with a mark, print his/her name on the appropriate line below and record the signatures of two responsible persons who witness that such person understands the nature of this acknowledgement.

If patient is not capable of signing the notice because of age or medical condition, complete the following:

Patient is a minor (____ years of age) OR Patient is unable to sign because _____.

Patient/Legal Guardian Date

Legal Guardian/Relative Relationship (if applicable)

_____/____/____ _____/____/____
Witness Date Witness Date